

District of Columbia

Report on Individual Premium Aggregation in the Health Benefit Exchange

Summary

The District's Health Benefit Exchange (HBX) is looking at two options for handling payment of individual health care premiums to issuers. This memo describes the background of premium aggregation, including the options the HBX should consider; the advantages and disadvantages of each; and identifies the next steps in determining which option to select. The District's HBX will begin enrolling individuals in QHPs effective January 1, 2014. All of these individuals will be responsible for paying all or a portion of their monthly premium costs. How this payment is collected needs to be defined so the premium aggregation responsibilities of the HBX can be determined.

Background

Premium aggregation is the process of collecting premiums owed in one month by individuals or families and paying an aggregated sum to Qualified Health Plans (QHPs) operating in the HBX. The Department of Health and Human Services (HHS) issued proposed rules distinguishing between individual and SHOP exchanges as they relate to premium aggregation. The proposed rule requires the SHOP exchange to aggregate premiums, but aggregation of premiums in the individual exchange is optional for states. The Affordable Care Act (ACA) specifies that "a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan" (Section 1312(b)). As a result, the District's HBX cannot require individual members enrolled in QHPs to remit premium payments to the HBX, but the HBX can provide members with the option to remit premium payments directly to the HBX. Any payment processing and aggregation services the HBX offers would therefore apply only to a subset of its members. Regardless of how an individual pays their premium, federal tax credits will be provided directly to issuers from the federal government.

Next Steps

Please provide comments on these options for individual premium aggregation in the District's Exchange to Rekha Ayalur (rekha.ayalur@dc.gov) by Friday, December 14th. After feedback is received from stakeholders, a summary report along with a proposed recommendation will be provided to the HBX Authority Executive Board for further review and approval.

Options for Individual Premium Aggregation in the District’s Health Benefit Exchange

Option 1	Option 2
HBX Collects Premiums	Direct Payment Approach
<p>SUMMARY</p> <p>The HBX would elect to manage the collection of individual premium payments from the subset of members who choose to remit payments to the HBX, aggregate the collected payments, and forward them to QHP issuers. The HBX would contract with a vendor to provide Individual premium aggregation services, as it is for SHOP premium aggregation.</p>	<p>SUMMARY</p> <p>The HBX would leverage the QHP issuers’ existing payment processing infrastructure and direct HBX members to provide premium payments directly to their QHP issuer.</p>
<p>PROS</p> <ul style="list-style-type: none"> ▪ Enrollees interact with the HBX for the entire shopping experience. ▪ HBX customer service assists with billing issues that create changes in enrollment. ▪ Complete enrollment and payment files sent to issuer at one time. 	<p>PROS</p> <ul style="list-style-type: none"> ▪ Issuers offering individual plans could leverage their current premium payment processes. ▪ Enrollees would pay premiums to the same organization that would coordinate benefits, care management, and other customer services. ▪ Lowest cost solution for the HBX.
<p>CONS</p> <ul style="list-style-type: none"> ▪ Requires the HBX to implement two sets of processes for tracking and reconciling premium payments, one for payments remitted directly to the HBX, and a second for those remitted to QHP issuers. ▪ Exchange bears the cost of performing monthly billing and financial transactions. ▪ Issuers’ current individual payment process is not leveraged. ▪ Coordinating monthly billing and grace periods with the Exchange creates an administrative burden for issuers. 	<p>CONS</p> <ul style="list-style-type: none"> ▪ Does not allow individuals a seamless enrollment experience within the Exchange system. ▪ Issuers and enrollees would need to coordinate with the Exchange concerning grace periods and billing changes and impacts on enrollment.

Public Comments on the HRIC Operations
Subcommittee's Individual Premium
Aggregation Report

December 14, 2012

BY ELECTRONIC MAIL

District of Columbia Health Benefit Exchange Authority
Attention: Rykha Avalur (rykha.avalur@dc.gov)
One Judiciary Square
441 4th Street, N.W.
Suite 1000 South
Washington, DC 20001

Re: Comments on Operations Subcommittee Report on Individual Premium Aggregation in Health Benefit Exchange

Ladies and Gentlemen:

This responds to the request for comments on the Operations Subcommittee Report on Individual Premium Aggregation in Health Benefit Exchange distributed by the Bulletin issued by the DC Health Benefit Exchange Authority on November 27, 2012 (the "Bulletin"). The Bulletin requests comments on two options for collection of premiums from individuals using the DC Health Benefit Exchange ("HBX") for selection and purchase of Qualified Health Plans ("QHPs").

Option 1 contemplates the HBX collecting premiums directly from individuals selecting and purchasing QHPs from the HBX. Option 2 contemplates such individuals selecting a QHP from the HBX, but then being directed to the issuer of the QHP selected to complete the purchase and make all premium payments for the selected QHP. Although Option 2 is referred to as the "Direct Payment Approach" and thus is seemingly a more simple and efficient process, Option 2 instead presents a more complex and less efficient method of premium aggregation for the HBX. For this reason, together with the reasons detailed below, Option 1 is the preferred method of individual premium aggregation to be adopted by the DC HBX.

The Bulletin lists four (4) specific "con" factors concerning Option 1. In truth, none of these factors detract from the appeal of Option 1.

1. The Bulletin states that Option 1 "{r}equires the HBX to implement two sets of processes for tracking and reconciling premium payments, one for payments remitted directly to the HBX, and a second for those remitted to QHP issuers." This statement is incorrect.

Implementation of the HBX to permit individuals to evaluate, select, and purchase QHPs from participating issuers will create an electronic infrastructure strongly suited to the electronic collection and remission of premium payments on both a one-time and recurring periodic basis. Even for those individuals who elect not to remit premium payments directly to the issuer of their selected QHP, the infrastructure required to permit the evaluation and selection of the QHP will additionally support the interchange of data between the issuer and the HBX to avoid the creation of duplicate processes for premium aggregation. This is for three reasons:

(A) In establishing the HBX infrastructure, systems can be included which facilitate both direct payment of premiums by individuals purchasing and receiving payment data from the issuers of QHPs where individuals purchasing those QHPs remit premiums directly to the issuer rather than through the HBX. Because the HBX and the issuers of QHPs will need to enter into agreements to allow the QHPs to be offered on the HBX, the HBX can include within those agreements with such issuers the requirement that the issuers report premium payment data from such individuals to the HBX. This is commercially appropriate and reasonable as the HBX must include the same type of reciprocal reporting to the issuer of QHPs for those individuals purchasing their QHP from the HBX.

(B) Most, if not all, issuers of QHPs already utilize third party administrators (“TPAs”) for the billing and collection of premium payments from insureds and policyholders. As the HBX will have a direct engaged relationship with each individual selected a QHP through the exchange, the integration of payment functionality to the HBX selection experience is appropriate and expected and simply positions the HBX as an alternative to the existing TPA generally used by the issuer of the selected QHP. As part of the process of contracting with issuers to place QHPs on the HBX, the HBX can simply include as an available option that the HBX serve as the TPA for the billing and collection premiums for the selected QHPs from each such issuer.

(C) The increasing use of electronic payment systems, including automated debit transactions using automated clearinghouse (“ACH”) transactions, electronic bill pay systems, whether by ACH or other electronic transfers, and use of automated recurring credit card charges to generally facilitate payments for recurring purchases favors use of the HBX as the method of collection of premium payments by the HBX as the most efficient method of individual premium aggregation. Inclusion of payment functionality within the HBX, together with the direct engagement between individuals and the HBX for QHP selection and purchase will promote the use of such functionality by individuals selecting their QHP through the HBX. No duplicative processes will be created.

In contrast, utilizing the Direct Payment Approach articulated under Option 2 will create inefficiency and require a multi-step reconciliation process whereby the HBX will need to manage multiple data flows from multiple issuers for all individual premiums requiring the creation of not one or even two processes, but potentially a dozen or more payment processing workflows in order to reconcile payments for QHPs selected through the HBX.

2. The Bulletin states the “Exchange bears the cost of performing monthly billing and financial transactions.” While true that operationally under Option 1 the HBX will be performing billing and financial transaction processing functions, the performance of these functions is a benefit to the HBX, not a sunk cost.

Under Section 1311(d)(5) of the Affordable Care Act, the HBX is required to be “self-sustaining” and to achieve that self-sustainability, the HBX is authorized “to charge assessments or user fees to participating health insurance issuers or to otherwise generate funding to support its operations.” This requirement and authorization favors Option 1 for individual premium aggregation as the benefits to the HBX of collecting premium payments more than cover the costs of performing the required financial transaction processing thus allowing the HBX to meet its requirement to be self-sustaining.

While issuers of QHPs resist payment of listing or similar user charges for access to the marketplace of individuals seeking QHPs through the exchange, and the charging of assessments or user fees on such individuals is anathema to the public policy of access to QHPs advanced by the existence of the HBX, the authorization of Section 1311(d)(5) of the Affordable Care Act provides for an alternative and generally-accepted method to “otherwise generate funding to support {HBX} operations.” To cover the costs of performing financial transaction processing contemplated by Option 1, the HBX needs merely to charge issuers a percentage of the premium amount assessed for the QHPs purchased.

This charge is identical to existing commissions paid to licensed benefits brokers who today market health insurance policies akin to QHPs to both individuals and groups through the health insurance marketplace. Issuers of QHPs expect and price their policies to contemplate payment of these commissions for the professional benefit brokers who presently market and support the purchase of health insurance policies and permitting the HBX to do the same for direct transactions with individuals selecting and purchasing QHPs through the HBX. While regulatory requirements may require accrediting the HBX as an insurance broker or insurance brokerage under applicable laws and regulations, apart from that ministerial matter, there is no limitation on the HBX meeting its mandate to be self-sustaining through exercise of its authority under the Affordable Care Act to collect a portion of premiums paid for purchase of QHPs through the HBX in lieu of the commissions generally paid commercially to benefit brokerages by issuers.

3. The Bulletin states that Option 1 is not attractive because “Issuers’ current individual payment process is not leverage.” This statement is incorrect but, nonetheless is irrelevant to the merits of Option 1.

Because individuals selecting QHPs through the HBX retain the ability to make premium payments either directly through the HBX or directly to the issuer of the QHP, for a subset of those individuals, the existing payment processes of the issuers will necessarily be leveraged by the HBX, particularly if the HBX leverages its own position as a marketplace to require integration of the issuers’ payment processes with the HBX. Further, as issuers’ current payment processes already make extensive use of TPAs for payment processing, the HBX can perform the same function, leveraging existing business processes of

the issuer (the outsourcing of payment processing to a TPA) by assuming the role of TPA for individuals selecting and purchasing QHPs through the HBX. In sum, Option 1 does leverage existing issuer payment processes, but that leverage is not a factor in using Option 1 as the preferred method of individual premium aggregation.

4. The Bulletin states that “coordinating monthly billing and grace periods with the Exchange creates an administrative burden for issuers.” As industry standards for remission of premium payments are consistent among issuers, this factor is not relevant to the merits of Option 1.

While each issuer of QHPs is free to establish their own respective policies concerning monthly billing and grace periods, advance billing with stated grace periods for receipt of late payments and provided notices of cancellation of policies of insurance are standardized through the health insurance industry, if not by stated industry standards, then by standard industry practices. Moreover, the HBX can establish standardized billing and grace period policies for issuers utilizing the HBX to offer QHPs to individuals, thus allowing the HBX to align as good public policy, the monthly billing practices and grace periods of all issuers offering QHPs. Thus, this factor is not an impediment to utilizing Option 1 as the preferred method of individual premium aggregation.

For all these reasons, Option 1 is the preferred method of individual premium aggregation. Option 1 fully leverages the technology and market infrastructure offered by the HBX. Only that leveraging through use of Option 1 for premium aggregation will assist the HBX in meeting the mandate of the Affordable Care Act that the HBX be self-sustaining. Statutory authority under the Affordable Care Act exists for the HBX to stand as a commissioned broker of QHPs to meet that requirement of self-sustainability. The use of Option 1 allows the HBX to become a seamless marketplace meeting the public policy goals of the Affordable Care Act by providing access to QHPs for individual uninsured persons, while allowing the HBX to self-sustain its operations.

Secure Exchange Solutions, Inc. is a DC Metro area-based provider of healthcare information technology solutions allowing for the secure electronic exchange of healthcare data and payments for healthcare services. Secure Exchange Solutions is an accredited Health Information Service Provider whose solutions are used by thousands of healthcare providers across the United States to enable the simple, secure and seamless communication of electronic healthcare data between and among providers and patients. More information on Secure Exchange Solutions is available at www.secureexsolutions.com

Respectfully submitted,

A handwritten signature in blue ink, appearing to read "Daniel I. Kazzaz".

Daniel I. Kazzaz
Chief Executive Officer

December 14, 2012

SENT VIA EMAIL

Ms. Rekha Ayalur
D.C. Health Benefit Exchange
Rekha.ayalur@dc.gov

**RE: D.C. Health Benefit Exchange
Public Comment – Individual Premium Aggregation**

Dear Ms. Ayalur:

This letter is in regards to the recent report on Individual Premium Aggregation in the Health Benefit Exchange issued November 27, 2012. We appreciate the opportunity to comment, and Delta Dental's position is that we favor the District conducting premium aggregation on behalf of the consumers who purchase their coverage via the District Exchange.

The report outlines two options for handling payment of health insurance premiums to issuers in the Individual market. Based on a review of the advantages and disadvantages of each option, Delta Dental's recommended approach in favor of the District performing premium aggregation is informed by the following:

- It will reduce the cost to issuers in the Exchange that results from payment administration, which could also benefit consumers in the form of lower premiums; especially with the low (by comparison with medical) fee structure of a typical dental plan, any effort to lessen the administrative challenges associated with premium collection has a beneficial impact on how we rate dental for the individual;
- It provides the Exchange with more control over enrollment and reconciliation of the Advance Premium Tax Credit (APTC);
- It provides a single point of contact for Exchange members to remit a single premium payment and address any problem resolution; and
- It allows the Exchange to offset its administrative costs by subtracting those amounts from the payments received, rather than bill the issuers separately.

For these reasons, we encourage you to adopt the option of Exchange-administered premium aggregation in the Individual Exchange. If you have any questions, please do not hesitate to call me at (415) 972-8418.

Sincerely,

A handwritten signature in black ink that reads "Jeff Album".

Jeff Album
Vice-President, Public and Government Affairs

Cc: Kevin Wrege

Date: December 14, 2012

To: DC Exchange: Rekha Ayalur

From: Susan Walker, D.C. Coalition on Long Term Care

RE; Individual Premium Aggregation

The D.C. Coalitions' main concern is that when an individual signs up for their health insurance that it is one stop shopping. When there are too many steps for the client to handle then often the client ends up not getting the benefit. By having everything done by the D.C. Exchange, hopefully, it would be a smooth, seamless process that would have the client leave with proof of having insurance and information about their plan. We also have the concern that if something goes awry with the enrollment and it is handled by the insurer that it will take far too long to rectify if the enrollment/payment is handled by two entities – the Exchange and the Insurer.

However, we have two concerns. D.C. has had a reputation in the past of not handling the transfer of payments in an expedited and efficient fashion. If insurers are going to participate they must receive their payments promptly and it must be a system that can be tracked easily. There should also be a liaison that can resolve problems effectively if they arise. And, of course, there must be safeguards to prevent fraud and abuse and to be sure that there are accounting reports that are transparent and timely.

As far as the Exchange bearing the brunt of the cost, the D.C. Coalition would hope that the most up to date and efficient computer systems would be put in place to decrease the cost to acceptable levels.

We know that the insurers want to handle collecting the premiums, but in reality, when dealing with large entities, whether employers or governments they are not collecting the premiums individually, but through an intermediary; the Exchange would be no different.



800 King Farm Blvd., Suite 600
Rockville, MD 20850

December 13, 2012

Rekha Ayalur
Department of Health Care Finance
District of Columbia
Washington, DC

Dear Rekha Ayalur:

Thank you for the opportunity to provide feedback on the options the District of Columbia is considering as it relates to individual premium aggregation in the Health Benefit Exchange (HBX). UnitedHealthcare is pleased to provide the following comments.

We would prefer to receive the premium directly from individuals, as long as the Exchange is well equipped to verify eligibility for the remaining portion of the premium that will come in the form of subsidies from the federal government. QHP Issuers are heavily dependent upon the Exchange's eligibility systems and the accuracy of information provided to the IRS, to ensure prompt receipt of premium funds. Consequently, early in this development process Exchanges should concentrate on putting effective and accurate mechanisms in place to facilitate not just eligibility but subsequent premium payment.

Therefore, we would recommend that the District select Option 2, the Direct Payment Approach outlined in the "Report on Individual Premium Aggregation in the Health Benefit Exchange". As the report indicates, this would allow the HBX to '...leverage the QHP issuers' existing payment processing infrastructure and direct HBX members to provide premium payments directly to their QHP issuer.' These processes are well established and the Exchange should not have to build an infrastructure to manage individual premiums. Building additional infrastructure to support premium aggregation would unnecessarily add cost and duplicate what issuers have in place today.

For purposes of the Individual Exchange, we believe QHP Issuers can and should be responsible for (1) enrolling individual consumers once a consumer has made his/her purchase decision, (2) collecting premiums directly from such individuals; and (3) reconciling subsidy administration for eligible individuals. We envision the process to occur as follows:

1. A consumer contacts the Exchange through the website or via phone to inquire regarding eligibility.
2. The Exchange evaluates the consumer's eligibility after collecting initial member data and communicates its eligibility determination to the consumer.
3. The consumer reviews purchasing options through the Exchange and selects his/her preferred QHP offering.
4. Consumer is transferred to the selected QHP Issuer's website/call center. The Exchange electronically transfers the eligibility data to the QHP Issuer.

5. At that time the QHP Issuer can work with the consumer to complete the full enrollment process, to include (a) obtaining bank account information and/or credit card information and authorization, and (b) coordinating billing and premium collection with the QHP Issuer website/call center.
6. After the QHP Issuer confirms receipt of the consumer's first month of premium payment, the QHP Issuer processes the enrollment and provides an acknowledgement back to the Exchange. This acknowledgment communication will provide a record of the successful completion and effective date of enrollment.
7. After enrollment, QHP Issuers will issue the member's policy documents, member material and ID card electronically through the website or via mail when requested.

The QHP Issuer will be responsible for ongoing monthly invoicing and payment /subsidy reconciliation with the consumer and designated federal department.

We recommend that the QHP Issuer bill the federal government directly for all subsidy payments versus the State Exchange. Subsidy payments should be sent to the QHP issuer monthly, in alignment with the consumer's bill/payment.

HHS and the Exchanges should establish standards around frequency of reconciliation for enrollment and billing to ensure a streamlined administrative process. QHP Issuers would therefore be responsible to ensure that Individual Exchange invoices reflect the individual's subsidy amount, consistent with the information the Exchange facilitates to the consumer on the Exchange website

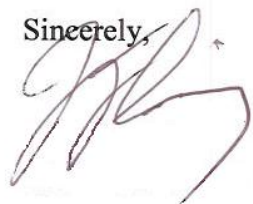
Additional Considerations:

- Enrollment should only be considered complete when the first premium payment is received. If only partial payment is received, the enrollment should be confirmed by the QHP Issuer only upon receipt of the full remaining balance of the premium.
- To reduce administrative burdens for all parties, we believe the QHP Issuer should be able to provide policy and member information electronically.

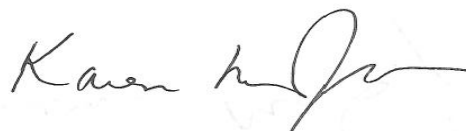
We believe this process will lead to a higher quality experience for the consumer and lower overall administrative costs: it streamlines the consumer experience by enabling the consumer to establish a relationship with their QHP Issuer directly and immediately upon enrollment, and it reduces the Exchange's capital investments and ongoing operating costs by tapping into Issuer's proven expertise in enrollment and billing.

If you have questions or would like to discuss our recommendations further, please do not hesitate to contact me. Thank you for your time and consideration.

Sincerely,



John E. Fleig, Jr.
Chief Operating Officer
UnitedHealthcare Mid-Atlantic Health Plan



Karen M. Johnson
Executive Director
UnitedHealthcare Community Plan
of District of Columbia



Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

December 14, 2012

Rekha Ayalur, Project Manager
Health Care Reform & Innovation Administration
D.C. Department of Health Care Finance

Re: Kaiser Permanente's Comments related to Individual Premium Aggregation

Dear Rekha Ayalur:

Thank-you for the opportunity to provide input on the District of Columbia Health Benefit Exchange Report on Individual Premium Aggregation. We offer the following comments for your consideration:

Significant Implementation Scope for 2014

Significant process and technology changes will be required to support the shopping and enrollment functions of the Exchange. Given the short timeline, the Exchange and carriers alike are required to make difficult decisions about what can and cannot be executed. Individual premium aggregation is a current capability of carriers. Kaiser Permanente views the DC Exchange's decision related to this function as an opportunity to decrease the already heavy workload of the Exchange.

Reconciliation Complexity

Based on Kaiser Permanente's ongoing experience as a carrier, keeping data from multiple systems in synch is a challenge. The member reconciliation process in the Exchange will also be complex. Adding the full range of financial reconciliation issues (i.e. partial payments, retroactivity, payment delinquency) to the member reconciliation process will result in added technical and process complexity.

Cost to Implement

Kaiser Permanente believes that there will be significant costs to both the DC Exchange and carriers to develop billing and reconciliation capabilities. Reusing the existing infrastructure of carriers will decrease the initial and ongoing costs associated with premium aggregation for both the Exchange and carriers.

Hybrid Billing Model Options

Kaiser Permanente does not recommend the use of a hybrid billing model, whereby, the initial payment and recurring billing and payment of the member can be done through either the Exchange or the carrier. Supporting these functions through either entity adds complexity to the shared business model between the Exchange and the carrier, and increases overhead costs. This approach would also be confusing to members. Further, the additional risk under the hybrid

billing model would require monitoring, management and mitigation. These additional management functions would put even more upward pressure on Exchange costs.

Conclusion

Kaiser Permanente believes that the accurate billing and collection of premiums is an important part of providing good service to consumers. We have robust systems, workflows, and experienced staff in place to ensure accuracy and ease the consumer experience for our current membership. We request that the DC Exchange consider using existing industry capability for the initial implementation and then evaluate the effectiveness of this approach after 2014.

Thank-you for your time and consideration. Please feel free to contact Laurie Kuiper, Senior Director of Government Relations, at Laurie.Kuiper @kp.org or 301-816-6480 if you have any questions.

Sincerely,

Laurie Kuiper
Senior Director of Government Relations
Kaiser Permanente

Jeffrey E. Tindall

Director, Regulatory & State Government Affairs



December 13, 2012

Rekha Ayalur
District of Columbia Health Benefit Exchange Authority
Rekha.ayalur@dc.gov

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900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.3160
Fax 860.226.1769
Jeffrey.Tindall@Cigna.com

Re: Individual Premium Aggregation

Dear Ms. Ayalur:

Cigna appreciates the opportunity to provide comments and questions on the District of Columbia's Individual Premium Aggregation report. We commend the deliberate and thoughtful approach to the complex issue of implementing the health benefit exchange for District residents.

Cigna is a global health services organization with insurance subsidiaries that are major providers of medical, dental, disability, life and accident insurance and related products and services. Cigna's mission is to improve the health, well-being and sense of security of the individuals it serves around the world. Key to our mission and strategy is our customer-centric approach; we seek to engage our U.S.-based and global customers by offering effective, easy-to-understand insurance, health and wellness products and programs that meet their unique individual needs. We achieve this goal by providing access to actionable information to ensure informed buying decisions, partnering with physicians and care providers in the U.S. and around the world, and delivering a highly personalized customer experience. This approach aims to deliver high quality care at lower costs for each of our stakeholders: individuals, employers and government payors.

Premium collection contains a significant administrative infrastructure and responsibility in the individual market. Individuals are accustomed to paying insurers and introducing the exchange as the administrator to accept payment may be confusing for the member. Also, adding an additional player in the administrative process may add confusion tracking who sent a payment to the differing entities.

A few questions for consideration if the District proceeds with the exchange collecting premium:

1) What methods of payment will be accepted? If the exchange accepts credit card payments, who pays the transaction fee? Does the District have existing processes for checks and money orders?

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2) The exchange will need business processes for overdrafts or insufficient funds of the individual. Is the exchange prepared to communicate information regarding grace periods, cancellations and nonpayment of premium in real time to issuers? Does the District currently possess the template to generate letters for premium payments past due? This process will require additional coordination between issuers and the exchange for those individuals who pay the issuer directly.

3) How does the exchange intend to track and reconcile the premium tax credit?

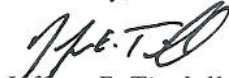
4) Will the exchange generate the bills to the individual as well?

5) Does the exchange intend to reconcile with the issuer changes in premium due to any plan change triggered by a special enrollment period as well as any additions/removals of dependents?

Several challenges exist for the District of Columbia, and all states creating a state-based exchange, to meet the January 1, 2014 deadline. The District may wish to focus its resources on implementing the exchange and permitting the carriers to retain collection of premium since they possess the experience and infrastructure to offer this service as currently provided.

Thank you for consideration of these comments and questions. Please contact me at 860.226.3160 with any questions.

Sincerely,



Jeffrey E. Tindall
Director, Regulatory & State Government Affairs

cc: Brendan Rose, DISB

Tonya Vidal Kinlow
Vice President
Government Affairs

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December 14, 2012

Rekha Ayalur
D.C. Department of Health Care Finance
899 North Capitol Street NE, Suite 6039
Washington, DC 20002

Dear Ms. Ayalur:

CareFirst strongly believes that carriers should continue to be able to perform billing and enrollment functions for individual consumers. Management of billing and enrollment for individuals is an extremely complex process. Coordination of these activities within an individual carriers' operation are well developed to ensure efficient and timely access to coverage and care. We believe transferring these operations to the Exchange would duplicate existing carrier processes and add unnecessary costs to operating the Exchange.

If, however, the Exchange decides that it should perform these functions, I have attached a series of questions that should be carefully considered, addressed and resolved before the Exchange decides whether it should internally perform the billing and enrollment functions for individuals who purchase plans on the Exchange. The issues raised in the attached only are relevant if the Exchange takes on the billing and enrollment function for individuals.

I would be happy to discuss these issues with you further or answer any questions you may have.

Thank you for your consideration

Sincerely,

A handwritten signature in cursive script that reads "Tonya Kinlow".

Tonya Kinlow
Vice President, Government Affairs—NCA
CareFirst BlueCross BlueShield

Enclosures

**Questions To Be Resolved If The Exchange Performs Billing And Enrollment Of
Individuals Purchasing Policies On The Exchange**

1. Invoices and cut offs for payment must match issuer receivables to minimize discrepancies. A carrier could cancel members for non-payment if the Exchange and carriers are out of sync such that payment is not timely received by the carrier. How would the Exchange propose to sync up with every carrier's billing cycle to avoid reconciliation issues? If dental and vision plans are sold separately from medical plans, how does the Exchange propose to sync up these various billing cycles in a seamless way for consumers?
2. Will the Exchange accept credit card payments from individuals for premium payments? If so, who will pay any credit card fees?
3. If the Exchange sends a coordinated single bill to an individual who has chosen separate carriers for health, vision and dental coverage, and the consumer is unable to pay the entire bill, how will the Exchange address the partial payment?
 - a. Under the federal regulations, a partial payment on a policy triggers a 90-day grace period, after which the carrier may terminate the policy if full payment is not received. Thus, attributing only a partial payment to one or more policies will have potentially severe consequences.
 - b. Will the Exchange prorate the partial payment among the three carriers, in the scenario above, or use some other method to allocate partial payments between carriers? Would the Exchange attempt to pay as many carriers in full first and apply the partial payment to only one carrier?
 - c. Would the Exchange have a policy or procedure to consult with consumers on how to apply partial payments across carriers?
4. How does the Exchange envision premiums collections will be handled? The process will need to include reconciliations, letters, terminations, and carrier notification.
5. What is the timeframe for termination of initial enrollment request if only partial payment is received? How will this be communicated to the consumer, and who will do the communication?
6. How will member calls be handled when a member's question includes both billing and claims issues? Carriers typically receive calls that deal with both issues. Will carriers answer the claims issue and refer the member to the Exchange for the billing questions and vice versa?
7. The fact of health insurance coverage is protected health information (PHI) under HIPAA. Members who call the Exchange with customer service issues related to billing may raise other claims issues that involve detailed medical information or other PHI. In addition, billing issues likely will involve Personal Financial Information (PFI), subject to regulations adopted following the federal Graham-Leach-Bliley Act. Carriers have adopted detailed procedures, contract limitations, and systems safeguards to protect such information.

- a. What are the Exchange's plans with respect to collection, retention, and confidential treatment of such PHI and PFI obtained during the process of administering billing and premium collections?
 - b. Will the Exchange serve as an intermediary between the carriers and the consumers for these issues? If so, what are the Exchange's plans to obtain authorizations under federal and state privacy laws to engage on behalf of consumers?
8. It is common that enrollment changes affecting billing occur after initial enrollment. How will these retroactive changes-such as addition of spouse/child- be handled in billing? Does the member contact the carrier or the Exchange and how will the information be shared in a timely manner between the Exchange and carrier? Moreover, coverage (claims) decisions often result from these changes in billing and enrollment. How will the Exchange handle the confidentiality issues raised by these coverage decisions? Will the Exchange refer the individuals to the carrier?
9. Today, all liabilities and risk involving billing and enrollment is borne on the carrier. How does the Exchange envision its responsibility of the liabilities and risk incurred in billing and enrollment of individuals? Does the Exchange take on the risk when errors in billing and errors in carrier notification occur that directly affect the insured?

Questions To Be Resolved About QHP Plan Decertification Policies

1. A consumer may have guaranteed renewability and portability rights under HIPAA to maintain his or her current health insurance coverage. If the Exchange decertifies a QHP, the consumer's plan would no longer be available on the Exchange, but it would still be an approved District of Columbia insurance product that the consumer may wish to keep. How does the Exchange propose to address this?
 - a. There may be instances where the consumer chooses to maintain their decertified plan outside the Exchange. Would there be a potential conflict between Exchange rules about the consumer's right to do this and HIPAA? Moreover, if in the future the consumer elects to come back into the Exchange, would the consumer have to reapply for Exchange eligibility?
 - b. For consumers who purchased their plan through the SHOP Exchange under the employee-choice model, there would be no comparable out-of-Exchange equivalent to the plan they can no longer obtain inside the Exchange. Further, while a consumer might choose to remain covered in a decertified plan, and has HIPAA renewability rights, that plan only existed in the context of the Exchange administering payments and other actions. If a SHOP QHP is decertified, how will the Exchange address the consumer's potential HIPAA renewability/portability requirement?
2. The Exchange is required to have an annual open enrollment period from October 7 to December 15 of each year. Federal regulations provide that mid-year decertification of a QHP would trigger a special enrollment period, allowing consumers in that QHP to enroll in other QHPs. Mid-year re-enrollment, however, may be disruptive to many consumers.
 - a. What procedures is the Exchange considering to align any decertification of a plan with the annual enrollment cycle or to otherwise minimize disruption to consumers? What is the effective date of termination from the decertified QHP? Will it be standardized to the first of the month? The date of QHP termination? Will the Exchange consider synchronizing the date of termination with the open enrollment period to create the least amount of disruption possible?
 - b. How long can an enrollee receive coverage from a decertified QHP after QHP decertification?
 - c. What are the premium payment and notice implications of this decision?