January 8, 2019

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

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments on the above-cited Notice of Proposed Rulemaking (NPRM).

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits, and to purchase affordable, quality health insurance. Since we opened for business, we've cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

We appreciate CMS's approach of seeking to give state-based marketplaces (SBMs) flexibility to serve local needs. However, some of the proposed changes will have the opposite effect and will restrict flexibility and impede SBMs' efforts. We oppose those changes and offer alternatives.

<u>Separate Invoicing for Non-Hyde Abortion Services (45 C.F.R. § 156.280(e))</u>

The proposal to require individual market issuers that sell through marketplace exchanges to send separate bills for the same policy just to collect the segregated premium for non-Hyde abortion services is unreasonable and beyond CMS's legal authority. It is contrary to insurance premium billing practices and inconsistent with section 1303 of the ACA. It creates new unnecessary costs that will be passed on to consumers through higher premiums, creates confusion for insured people, and will cause women to lose abortion services coverage or coverage altogether. We strongly oppose this proposal and urge CMS to withdraw it.

The prosed rule is not in accordance with law because it conflicts with the relevant statute. As CMS states in the preamble, the statute does "not specify the method a QHP issuer must use to comply

with the separate payment requirement under section 1303(b)(2)(B)(i)."[1] However, there is statutory text that directly answers the question of whether monthly notices can be sent. Section 1303(b)(3) of the ACA directs how customers are to receive information regarding individual market qualified health plans that provide non-Hyde abortion services. Such carrier or exchange notifications can only provide information "with respect to *the total amount of the combined payments* for [non-Hyde abortion services] and other services covered by the plan." (emphasis added). The proposed rule directly conflicts with this statutory text because it would require the issuer to separately notify the customer on a monthly basis of the non-Hyde services related portion of the premium. Therefore, when reading section 1303 as a whole, the Proposed Rule's requirement that issuers must send separate invoices, or separate notifications related to non-Hyde abortion services, is in excess of CMS's statutory authority and thus unlawful.[2]

Additionally, the proposal is not reasonable. It contradicts well-established industry practice – one bill for the entire premium for a set period, e.g., monthly, quarterly, semi-annually, or annually. This is the case for health, auto, homeowners, and liability insurance policies. Billing systems for insurance are set up to produce one combined bill and generate additional invoices only if there is a late payment or a change to the policy, like adding dependents or new employees. Even if there are riders to a policy, the policyholder receives one bill, not separate bills in separate envelopes, as CMS proposes. CMS does not offer any examples where the proposed approach is used for insurance billing. CMS fails to support its proposal with evidence that the approach is reasonable. Such an unreasonable requirement is arbitrary and capricious, and is therefore unlawful.

The proposal to require separate invoices is also completely unnecessary to achieve the congressional objective of segregating funds and ensuring no federal funds are used for non-Hyde abortion services. It is a solution for a non-existent problem. For the last 5 years, issuers have been executing the CMS-approved methods[3] of achieving Congress's intent of having issuers segregate these funds, but without the severe negative consequences described below.

CMS's proposal will increase premiums for people in the individual market. The new unnecessary costs that issuers will incur implementing this requirement will be passed along to consumers through premium increases. Issuers will have to redesign their billing systems for a small portion of their business – individual exchange marketplaces. This means expensive IT changes, creating and operating a billing system only for individual marketplaces and not for products sold in any other market. There will also have to be changes to operations – invoice processing, collections, customer service support, EDI transactions with marketplaces, etc. There will also be new administrative costs of mailing separate bills in separate envelopes, and collecting separate payment (even if combined payment is accepted). None of these changes are cost-free, and costs will be passed onto consumers through higher premiums.

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[1] Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Notice of Proposed Rulemaking, "Patient Protection and Affordable Care Act; Exchange Program Integrity" 83 Fed. Reg. 56,015, 56,022 (Nov. 9, 2018).

[2] 5 U.S.C § 706.

[3] Centers for Medicare & Medicaid Services, "CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act," (Oct. 6, 2017), https://www.cms.gov/CCIIO/Resources/Regulationsand-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf.

According to a recent report by the Kaiser Family Foundation, at highest risk for premium increases due to increased costs for IT and new operations are people who live in California, New York, Oregon, and Washington.[4] These states require abortion services to be covered by issuers.[5] Also at high risk are people who live in states where abortion coverage is not banned and is available through marketplaces.[6] These states include Alaska, Colorado, Connecticut, Hawaii, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, Rhode Island, Vermont and the District of Columbia.[7]

There is also substantial risk that some issuers will not want to build new IT billing and operations systems for a small book of business. Those issuers will either leave marketplaces or drop coverage for medical services related to abortion procedures. People at highest risk of losing abortion services live in the District of Columbia and 12 states that do not require abortion coverage but health insurance covering abortion services is currently available.[8] If issuers drop coverage for abortion, thousands of District residents and millions of women and men across the country will be impacted. Cost for such medical procedures will be shifted from insurance companies to women and families.

In summary, we strongly oppose the proposed change to 45 C.F.R. § 156.280(e) because it will:

1. Cause premiums to increase due to the cost for new billing systems;
2. Cause people to lose coverage because of failure to pay two different bills;
3. Cause some insurers to leave marketplaces because the costs for a new billing system will exceed benefits of staying;
4. Cause some insurers to stop offering coverage for abortion services, which shifts cost to women and leaves women of childbearing years without coverage;
5. Hurt women and women's access to medical care.

Periodic Data Matching (45 C.F.R. § 155.330(d))

HBX appreciates the proposed regulatory approach and the recognition that SBMs and Medicaid agencies work together closely and share eligibility systems. We support the proposal to deem compliance for such SBMs. We encourage CMS to recognize that there are different ways SBMs and Medicaid agencies share eligibility systems, and as technology continues to improve, it is important to recognize changes.

Programmatic and Financial Oversight (45 C.F.R. § 155.1200)

We greatly appreciate staff from CMS who work with SBMs, including HBX, assisting SBMs, conducting oversight and extensive follow-up, including site visits. We also appreciate the

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[4] A. Salganicoff and L. Sobel, "Abortion Coverage in the ACA Marketplace Plans: The Impact of Proposed Rules for Consumers, Insurers and Regulators," Kaiser Family Foundation, Issue Brief (Dec. 2018), http://files.kff.org/attachment/Issue-Brief-Abortion-Coverage-in-the-ACA-Marketplace-Plans.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] A. Salganicoff and L. Sobel, *supra* n.5.

proposed modification to § 155.1200(d)(2) indicating that the focus of external audits shall be on eligibility and enrollment (subparts D and E). This clarification helps SBMs, including HBX, to prioritize resources for these two principal function areas. We recommend deleting ". . . or other requirements under this part 155 as specified by HHS" because it is ambiguous and is not necessary. An annual external audit focusing on subparts D and E does not eliminate reporting requirements to CMS under § 155.1200 related to other part 155 subparts.

Additionally, HBX seeks transparency about CMS's oversight of the FFM and compliance by the FFM. The FFM has the same status and statutory basis as SBMs.[9] However, it appears that SBMs are subject to different and higher oversight than the FFM. For example, § 155.1200(c)(3) requires SBMs to make the results of their annual programmatic audits public, but the FFM does not do the same. This makes it difficult for us to compare and better understand issues and approaches to addressing findings. While external agencies such as the U.S. Government Accountability Office or the U.S. Department of Health and Human Services Office of Inspector General conduct audits of the FFM, and the reports are public, these audits do not occur on an annual basis, and they cover specific topics rather than the full breadth of 45 CFR Part 155, as currently required of SBM external audits under § 155.1200(c). We recommend for CMS to publish a comparison of standards and oversight activities that CMS conducts of the FFM and SBMs. CMS should ensure that SBMs and the FFM are subject to the same compliance and audit requirements with the same breadth and frequency. CMS should not disadvantage SBMs compared to the FFM.

Conclusion

Thank you for considering our comments on these issues that will directly impact District residents and the continued operations of our marketplace.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority

[9] *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (the federal exchange is "the same Exchange that the State was directed to establish").