blue of california

January 8, 2019

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

Submitted via www.regulations.gov

Re: [CMS-9922-P] RIN 0938-AT53 Comments in Response to Proposed Rulemaking: Patient Protection and Affordable Care Act; Exchange Program Integrity

Dear Administrator Verma:

Blue Shield of California ("Blue Shield") appreciates the opportunity to respond to your Proposed Rule on Exchange Program Integrity. Blue Shield is a nonprofit health plan that offers health benefits coverage to individuals and groups throughout the State of California. Our mission is to ensure that all Californians have access to high quality care at an affordable price. In 2011, Blue Shield was the first, and remains the only, health plan to voluntarily place a cap on its earnings. Since then, we have limited our net income to 2 percent of our annual revenue.

Blue Shield is writing to express our strong opposition to a provision in the Proposed Rule which would single out enrollees in states that require non-Hyde abortion coverage as part of the basic health benefit. Blue Shield currently enrolls approximately 435,000 members in qualified health plans (QHPs) who would be impacted by this rule. As opposed to current requirements that permit enrollees to pay their entire premium—including the amount required for non-Hyde services—in a single transaction, under the Proposed Rule enrollees would be forced to pay two separate bills in two separate transactions for their Affordable Care Act (ACA) coverage.

Importantly, this policy change could force enrollees to face cancellation of their coverage—with no opportunity to re-enroll during the calendar year—for failure to pay as little as $1 a month. What is more, implementing this policy to bill separately for non-Hyde services will cost insurers like Blue Shield far more to implement and operate than would be collected. This would run directly counter to the Administration's overall mandate to reduce the burden of regulation. Because existing policies in place related to segregation of funds meet both the letter as spirit of the law, this policy can only be understood as an attempt to impose an arbitrary political penalty on states offering non-Hyde abortion services. For this reason, we strongly urge that the Proposed Rule be withdrawn.

The Proposed Rule Does Not Consider the Real-World Impacts of the Policy:

In California—along with several other states—access to abortion coverage is a state mandated benefit. This requirement took effect long before the ACA was enacted. Access to abortion therefore must be included as part of the essential health benefit package included in all individual market and QHP coverage.

The ACA requires that any funds for non-Hyde abortion coverage be paid from a segregated account which is not funded by, or comingled with, federal tax dollars. Blue Shield and other insurers comply with both the letter and spirit of the law by creating a process to separately track and pay claims for non-Hyde abortion services. This process must be described to our state regulator and filed along with required plan documentation for individual market coverage. Blue Shield is not aware of any concerns regarding the process we have established related to comingling of federal tax credits and reimbursement for non-Hyde services.

The proposal from HHS does not consider the real-world implications of the policy and what it would mean for coverage. Under the rule as proposed, individuals who fail to pay as little as $1 per month would face mandatory cancellation of their policy—with no opportunity to re-enroll until the next calendar year. HHS in its proposed rulemaking did not consider how many people would fail to pay this amount considering the time required to write a check and pay for postage for such a small bill. In addition, close to 100,000 of our Exchange members now automatically re-enroll in coverage by continuing to make payments automatically through an approved credit card transaction. Under the Proposed Rule if finalized, all these members would likely be confronted with a separate authorization they would have to approve to add a new credit card transaction for $1 per month. If they fail to authorize this transaction, coverage could be required to be cancelled even though the enrollee would believe their premiums were being automatically deducted.

Finally, given the administrative complexities of implementing this policy, plans could not be ready by the 2020 plan year as suggested in the Proposed Rule. A 2020 effective date would mean that all system changes would have to be in place by September of 2019 in order to test for open enrollment. It would take at least 18 months to put these changes into place, requiring a delayed implementation date.

The Cost of Implementing the Rule Would *Dramatically* Exceed HHS Estimates:

The Proposed Rule *dramatically* understates the financial impact of this rule to carriers. The variance between the regulatory assessment and Blue Shield's analysis suggests a striking gap in the understanding of the implementation costs and challenges of the rule. HHS estimates the total cost of implementing the rule to be $841.60 per issuer, or $63,120 for all insurers nationwide. In addition, it estimated ongoing compliance costs would be $1,453.43 per year per issuer.

In contrast, our internal estimates show *it would cost $4-$6 million for Blue Shield alone* to implement this policy—separate from the monthly costs of operationalizing this requirement. This is driven by the cost to reprogram systems to send multiple bills for a single policy—which is not an existing option for Blue Shield or many other carriers. It also reflects the increased complexity with duplication of bills/payments to single households and the establishment of

parallel processes affecting claims, billing, enrollment, customer service, and financial processing. In addition, we would expect current grace period and delinquency volume to grow by 40%-60%, given the confusion of separate bills and the likelihood of not paying both bills each month. As a reminder, when members are in their grace period, provider payments are pended so there would be an increased number of provider complaints.

In addition, the requirement would add $900,000 per month in ongoing operational costs including:

- $600,000 to print and mail (approximately 300,000 bills at $2 a bill).
- $125,000 for additional customer service related resources to support and address member calls and increased delinquency volumes.
- $125,000 for additional billing and reconciliation resources to support increased volume of payment processing, delinquency volumes and reconciliation processes.

In summary, the requirements in the Proposed Rule would cost dramatically more for insurers to implement and operationalize than considered in the rulemaking. This demonstrates that the agency did not appropriately understand and weigh the impacts of this Proposed Rule. The rule should therefore be withdrawn and reevaluated considering this evidence.

States Should Remain the Primary Enforcer of this Requirement:

HHS notes that states remain the primary enforcers of these requirements related to segregation of funding for non-Hyde services. We believe that the requirement to mandate two separate billing transactions for a single policy runs counter to this delegation of enforcement and should not apply to any state which has procedures in place to oversee these requirements. Instead, HHS should review enforcement procedures in each state and address any perceived inadequacies through their existing oversight authority.

Conclusion:

The weight of evidence is clear that the Proposed Rule would impose costs far in excess of any benefit and result in impacts to coverage that were not appropriately considered by the agency in its rulemaking. Accordingly, we ask CMS to withdraw this policy.

Sincerely,

Andy Chasin
Policy Director
Blue Shield of California