DC Health Benefit Exchange Authority

District of Columbia Health Benefit Exchange

Premium Billing Working Group Findings and Recommendations

Background

The Affordable Care Act (ACA) and associated federal regulations have established certain requirements for health benefit exchanges with regard to billing and collection of individual and small group premiums. Exchanges must perform all billing and collections activities for small group premiums, known as the Small Business Health Options Program (SHOP). Individuals must be given the ability to pay a carrier directly, but each exchange may offer individual enrollees the option to pay the exchange. (It is considered likely that, if given the option to complete enrollment and payment through the exchange in a single transaction, most enrollees will simply opt for paying the exchange directly rather than insist on the extra step of generating a bill from the issuer.)

In response to this open policy question the DC Health Benefits Exchange ("the Exchange") formed a working group chaired by Henry Aaron, PhD., to assess the various options available to the Exchange and, if possible, unanimously recommend a course of action with respect to premium billing for individuals. The vice-chair, Chris Gardiner, was unable to fully participate due to scheduling conflicts.

In advance of the working group meetings the Exchange had provided an overview of the issue and solicited feedback from stakeholders. These documents, along with a background paper prepared by Wakely Consulting, served as the basis for the initial working group discussions. The working group identified additional information required to assess the issue, and tasked Wakely to do the corresponding research. Wakely's background paper, additional research, and meeting notes are appended to this report.

Primary Options Identified/Considered

At its first meeting, the working group identified three options for consideration:

1. The Exchange could contract with the premium billing vendor for SHOP to build and operate a premium billing system for the individual (non-group) market. (As described above, individuals could still exercise the option to pay issuers directly.)

2. The Exchange could choose not to perform premium billing and collection for the individual (non-group) market, meaning that issuers would perform all non-group billing and collections.

3. The Exchange could implement a hybrid approach, similar to Maryland's, to bill individuals as part of the initial enrollment, after which the issuer bills the enrollee for subsequent months. Because enrollment is not complete until the first month's bill is generated and paid, having the Exchange perform this function as part of eligibility determination and plan selection creates one-stop shopping for the full range of transactions.

Key Determining Factors

Wakely's background memo (appended) identifies six criteria for assessing the options:

1. Strategic Considerations (for Exchange & Issuers)
2. Financial
3. Ability to Implement Timely
4. Enrollee Experience (Customer Service)
5. Reporting
6. Oversight & Monitoring

After lengthy discussion, the working group prioritized and focused on four criteria: the ability of the Exchange's selected vendor and carriers to implement billing systems in a timely manner; providing the enrollee with a smooth, easy enrollment experience and good customer service; strategic considerations related to ongoing communications with enrollees; and the cost of performing premium billing and collection. The first criterion was viewed as a "gating" item, since the inability to implement premium billing systems on time would jeopardize the Exchange. It was determined through discussions with insurers and the Exchange's vendor that all three options above could be implemented in timely fashion, so long as the Exchange makes a decision and starts working with the carriers and/or vendor in March.

Therefore, each of the three approaches was deemed feasible. The working group went on to assess each one in terms of consumer experience, cost, and the strategic considerations described below. The imperative for a quick decision by the Board and expeditious follow-up by staff with issuers and the vendor is an important element of the working group's recommendation.

Consideration of Key Factors

As noted, three criteria were identified by the working group as key to discriminating among the three options identified initially:

- Enrollee Experience – The enrollee experience is a major concern for all stakeholders and will greatly impact the public perception of the Exchange. The working group discussed several concerns about customer service:

- Ensuring that members have a smooth and complete experience at the time of enrollment. Consumer advocates noted that a billing option which requires handing off individuals from one organization to another during the enrollment process is likely to increase the inconvenience to enrollees and the risk of not actually completing the enrollment process.
- Consumer advocates voiced concern over the ability of multiple entities to provide consistent customer service, especially for a single household enrolled with multiple issuers. (Individuals within a household can select different medical and/or dental issuers.)
- Another concern is that multiple bills from different issuers would prove to be confusing to enrollees and challenging for both enrollees and issuers, particularly for families on limited budgets who may make partial payments on a weekly basis.
- Some health plan representatives voiced concern about the ability of the Exchange to provide good customer service and accurately collect premiums, when it has no previous experience and is rushing to put all its systems in place for start-up.

- Strategic Considerations –A range of strategic considerations are laid out in the background documentation and several weighed heavily in the working group's deliberations:
  - Under the ACA guidance, issuers will be required to accept payment from individuals and are already making modifications to existing billing systems to provide this capability. Therefore, building this capacity at the Exchange is duplicative.
  - On the other hand, without the capability to step in and perform billing and collection for any issuer that fails to perform this function well, the Exchange would have little choice but to suspend enrollment with that issuer.
  - The issuers view the monthly billing and collection process as a key "touch point" with their members. Monthly communications allows the plans to access the most up-to-date information on the members and build a good working relationship with the member.
  - Similarly, if the Exchange were to perform the role of billing and collections, it would be able to communicate more readily with enrollees about open enrollments, changes in issuers and QHPs, new exchange programs, etc.
  - Consistency with the approach taken by Maryland is appealing because it will reduce the workload for issuers that operate in both jurisdictions and may reduce confusion for enrollees as well.

- Financial Considerations – The working group chose to break down financial considerations into two components: initial costs to build/transform an existing premium billing system and ongoing costs to maintain and operate the billing and collections system.
  - Under the ACA guidance, the Exchange is required to build premium billing and collections capabilities for the small group market. This "build" will entail both the IT

systems build and ongoing operations, so the cost for non-group billing and collection was estimated as incremental cost for adding this component.

- Issuers will have to adapt their systems regardless of the Exchange's decision, but ongoing operating costs presumably will vary with volume.

Consensus Reached

After reviewing and assessing the key considerations described above, the working group was able to reach a consensus. The recommended course action is for the DC Exchange to adopt a hybrid model for premium billing in the individual (non-group) market, similar to Maryland's approach. This hybrid model would work as follows:

1. All billing and collection of payments for an individual's initial enrollment (or subsequently switching issuers) will be performed by the Exchange.
2. The Exchange will then pass the first month's premiums and enrollee information to the issuer(s) for effective enrollment.
3. After the first month's billing and payment are completed and the enrollment information is passed from the Exchange to the issuer(s), the responsibility for subsequent month's billing and collection functions pass to the respective Issuer of a Qualified Health Plan(s) selected by the household.
4. The Exchange will develop policies and procedures to address billing and collections during future open enrollment periods; however, it is suggested that during these enrollment periods a change in carrier would result in an initial billing from the Exchange while renewal with the same carrier would result in a continuation of billings from the existing carrier.

The working group felt that this hybrid model best addressed all of the key concerns from the respective stakeholders. The following reasoning is provided in support of the working group's recommendation:

1. <u>Enrollee Experience</u> - It was determined that the best customer experience throughout the enrollment process would be to have all functions of enrollment, including billing and initial payment, performed by a single entity. Because the Exchange is responsible for all elements of eligibility determination and plan selection, it should complete enrollment collecting the first month's premiums. This approach should provide a smooth enrollment experience and reduce the risk that potential enrollees do not complete enrollment.

   This approach also addresses concerns that the enrollee will have inconsistent experiences with different issuers at the time of enrollment; however, it does not address concerns regarding different experiences once the issuers take over ongoing billing and collections.

2. Strategic Considerations - The issuers have experience performing ongoing premium billing and feel that they can best serve their member's needs as the key contact for those members throughout the billing year. In particular, they point to the advantage of having a single point of contact for billing, claims and most other plan-related customer service issues throughout the year. Accurate premium billing and collection determines their revenues, so properly "belongs" in their hands. Moreover, issuers can more easily communicate with members regarding their plan options, changes in policies, etc. throughout the year.

   Generally, there would be concern by the Exchange that it is losing a key strategic connection with its members; however, this concern is mitigated by the D.C. Exchange's decision to create a unified market which ensures that all individuals – other than those enrolled in grandfathered plans – will enroll or change enrollment through the Exchange.

3. Financial Considerations -While this recommended course of action requires the Exchange to build out the premium billing and collection capability for individuals, the projected incremental expense of this build-out was estimated by the vendor to be relatively modest, and funds to pay for the initial build are available through existing federal grants. The ability to maintain that system during ongoing operations, again as estimated by the vendor, does not appear to be burdensome. The Exchange is already required to build and maintain billing and collection services for the small group market and the additional effort and cost to maintain that system for the individual market will not be a significant undertaking. In particular, the vendor will be paid per monthly billing cycle, so dividing billing between the Exchange and the issuers should not materially increase total operating costs. Furthermore, the Exchange must have the IT and operating capabilities to track individual premium and Advanced Premium Tax Credit (APTC) amounts, so much of the capabilities needed will have already been put in place. However, by contrast with a decision to delegate non-group billing entirely to issuers, it is the case that the issuers must build and operate control systems for monitoring the accuracy of the Exchange's first-month billing and collections.

   High-level vendor estimated costs:
   a. Start-up costs = $125,000 (allowable to be purchased with federal grant money)
   b. Ongoing PMPM costs = $1 PMPM (estimated at 40,000 members) with 3% increase each year

Additional Factors:

As noted above, the working group reached consensus on the hybrid method described above. This consensus was gained with the understanding that respective stakeholder groups each had differing opinions of the most effective option. Various medical plans noted that their preferred outcome would

have been a billing arrangement that was performed entirely by the issuers; however, they concede that the hybrid method that is being recommended by this working group is an acceptable compromise.

By contrast, several stand-alone dental carriers expressed a preference for the Exchange to do all the billing and collection for them. They note that because dental premiums are relatively small by comparison with medical premiums, the cost of separately billing for dental will represent a substantial percentage of stand-alone dental premiums. However, the other members of the working group concluded that this was a cost of stand-alone dental plans that consumers could choose to by-pass by selecting integrated plans that offer medical and dental coverage in a single package. Similarly, if family members prefer to enroll with different medical issuers, they should bear the extra work and possible confusion of paying separate monthly invoices from each issuer.

Consumers represented in the working group preferred that the Exchange integrate all billing and collections for all issuers with eligibility determination and enrollment, so that families split among issuers might receive just one bill, that decisions about how to allocate partial payment, termination for late or non-payment, etc. would be made consistently, and that the Exchange would be positioned as the hub of communications with enrollees. However, they conceded that the most important hand-off is at the time of eligibility determination and at the time of switching issuers, so that running the first bill at such times through the Exchange would go a long way toward smoothing the process for consumers.

Overall Conclusion

Overall, this working group has taken its charge from the Exchange very seriously and put a great deal of thought and effort into exploring the various options and coming to consensus on a recommended course of action. We want to thank the Exchange for this opportunity to present our recommendation. Implementing the recommended course of action, referred to as the hybrid approach, will likely generate a variety of additional policy and procedural decisions. We recommend that the Exchange continue to work closely with the respective stakeholders, primarily, issuers, consumer advocates and insurance brokers, to ensure that the policies and procedures that are developed are optimal for all parties involved while maintaining a goal of providing the highest level of support and service to the individual members of the Exchange.

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**
SUMMARY 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.	**SUMMARY** The HBX would leverage the QHP issuers' existing payment processing infrastructure and direct HBX members to provide premium payments directly to their QHP issuer.
PROS ▪ 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.	**PROS** ▪ 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.
CONS ▪ 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.	**CONS** ▪ 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

Secure Exchange Solutions

December 14, 2012

BY ELECTRONIC MAIL

District of Columbia Health Benefit Exchange Authority
Attention: Rykha Avalur (reykha.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 form 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 in 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 additional 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 in 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,

Daniel I. Kazzaz
Chief Executive Officer

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deltadentalins.com

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.

Delta Dental of the District of Columbia
Administrative Office
One Delta Drive
Mechanicsburg, PA 17055-6999

Administrative: 800-471-7091
Customer Service: 800-932-0783
TTY/TDD: 888-373-3582

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,

Jeff Album
Vice-President, Public and Government Affairs

Cc: Kevin Wrege

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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 individuals 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 at 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.

UnitedHealthcare®

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

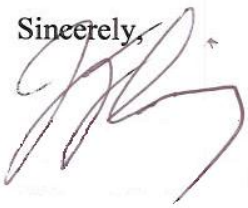
Additional Considerations:

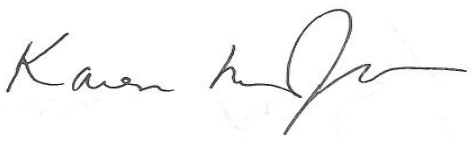
- Enrollment should only be considered complete when the first premium payment is received. If only partial payment is received, the enrollment should be confirmed by the QHP Issuer only upon receipt of the full remaining balance of the premium.
- To reduce administrative burdens for all parties, we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

KAISER PERMANENTE®

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 than 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

2101 East Jefferson Street
Rockville, Maryland 20852

Jeffrey E. Tindall
Director, Regulatory & State Government Affairs

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

December 13, 2012

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

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?

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

CareFirst BlueCross BlueShield
840 First Street NE, Suite 1200
Washington, DC 20065-0001
Tel. 202-680-7444
Fax 301-470-3751

CareFirst BlueCross BlueShield

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,

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?

WAKELY CONSULTING GROUP
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District of Columbia Health Benefit Exchange

Background Briefing on Business Considerations Regarding Implementation of Premium Billing for the Non-Group Market

The District of Columbia's Health Benefit Exchange (Exchange) is currently assessing two options for handling billing and collection of individual premium payments from individuals who enroll in Qualified Health Plans (QHPs) through the Exchange. As a supplement to the background memo prepared by the Exchange and the comment documents received during the open comment period (attached), the following memo has been prepared to provide additional business considerations regarding the premium billing options that are currently proposed.

The business case for whether or not an exchange or the issuers of QHPs should perform the premium billing function for the non-group population is complex, and as the summary document previously prepared by the Exchange highlights, there are numerous pros and cons to each option. First, it should be understood that the ACA *requires* that individual (non-group) subscribers have the option to pay their share of premiums directly to issuers, even if an exchange bills and collects premiums itself; and no matter who does the billing, the Advance Premium Tax Credits will be paid by Treasury (IRS) directly to the issuers, so the two options* under debate are:

1. All non-group premium payments (IRS & subscribers' shares) go directly to the issuers; or
2. An exchange does the billing and collection from the subscriber, except for those non-group subscribers who prefer to pay their share of premiums directly to the issuer, while the Treasury pays its share directly to the issuer.

Second, premium tax credits (APTC), regulations regarding enrollees in a non-payment status (grace period), and the potential for a high degree of churning between the exchange and other public subsidized programs, require a premium billing system with a greater degree of flexibility and enhanced functionality than solutions currently operating in health insurance plans. Developing such systems will be a challenge for both the Exchange and the issuers.

There are legitimate concerns that having issuers and the Exchange operating their own premium billing systems could be wasteful or duplicative. However, these concerns should be weighed against the prospect that without the option to pay the Exchange, an individual consumer's shopping experience would be fragmented when he/she "jumps" from the Exchange to the issuer for initial premium

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*A third, "hybrid" option, which Maryland has adopted, is for the exchange to issue the first month's premium bill and collect the subscriber's portion, and subsequent billing and collection is done by the issuers.

payment; and enrollees will be dependent on the ability of every issuer to provide consistent, reliable billing services. Without an option for the Exchange to do the billing and collection if an issuer cannot perform this function well, and only one issuer fails to meet reasonable performance standards, the Exchange will be "stuck" with the resulting problems and cannot offer an alternative to consumers, the IRS or any of its other business partners.

Third, the ACA requires an exchange to develop a premium billing system for the Small Business Health Options Program (SHOP), regardless of whether an exchange chooses to bill for individual (non-group) premiums. As such, the incremental cost of added billing capabilities for non-group should not be assumed at the price of a new system but rather, should be assessed at the incremental rate.

Fourth, this analysis is further complicated by the fact that the identity of the party which performs the billing and collection function will create a number of opportunities and risks for all concerned. An important opportunity/risk for consumers is whether or not they can enjoy an uninterrupted, one-stop shopping experience, from eligibility determination through shopping to enrollment and premium payment. If, upon selecting a QHP to join, the non-group consumer must transfer to the issuer in order to generate a bill and pay the first month's premium (in order to complete enrollment), this can create a significant interruption or discontinuity in the consumer's shopping experience. It is hypothesized that if the consumer can complete the transaction through the Exchange (customer service call or web enrollment), most will choose to do so, rather than transfer or link to the issuer.

The opportunities and risks for the Exchange and for issuers, depending on who does the billing and collection, include the following: direct marketing as part of the monthly billing process, monthly communications with enrollees on various topics (e.g., annual open enrollment, changes in plan features, changes in federal subsidy levels, Medicaid/CHIP eligibility, and preventive health messages), performing a key aspect of customer service well or poorly, initial development costs, scale economies for ongoing operations, and ongoing maintenance concerns with both IT systems and internal control systems.

Taking this complexity into account, we recommend the following framework for analyzing whether the Exchange should implement a premium billing solution for the non-group market:

1. Strategic Considerations (for Exchange & Issuers)
2. Financial
3. Ability to Implement Timely
4. Enrollee Experience (Customer Service)
5. Reporting
6. Oversight & Monitoring

1. Strategic

Because premium billing and payment are important to enrollees they are likely to pay attention to this communication. Therefore, it provides the Exchange (or issuer) with a cost-effective channel for communicating important information such as upcoming open enrollment, rights and obligations under the ACA, changes to QHPs and QHP benefit offerings, as well as expected premium rate changes and cost-effective alternatives, in an objective, carrier neutral (if performed by the exchange) manner.

Additionally, for carriers that do not have a robust individual premium billing system, including Medicaid Managed Care Organizations and some dental carriers, the Exchange's ability to do premium billing and collection enhances the potential for carrier competition. It removes an operational obstacle that could otherwise discourage a carrier from participating as an Issuer of QHPs. (Such issuers are likely to refer enrollees back to the Exchange for billing and payment and/or handle manually the small volume of enrollees who insist on paying the issuer.)

Conversely, many issuers who will likely provide QHPs do already have billing systems (or relationships with TPAs). These will need to be reviewed and potentially modified to ensure that they are able to process payments directly from individuals, in accordance with ACA guidance. These issuers will view the direct access and regular communications with the member in same positive manner as described above for the Exchange, and will see the Exchange's role in the billing process as duplicative, since the issuer must provide billing and collections capabilities under either scenario.

An additional strategic consideration is public perception of competence. There is a significant risk that any billing and collection issues that are visible to the enrollees and stakeholders will take a toll on the credibility of health reform, the Exchange and, by extension, DC government. How best to mitigate this risk is debatable: if the Exchange takes on this function, it risks start-up problems, but if it cannot perform this function well or misses the deadline for start-up, it has a back-up alternative for consumers in the requirement that issuers be able to perform this function; conversely, if the Exchange delegates this function entirely to issuers, and any one of them fails to perform well, the Exchange will share the blame for the resulting problems and will have no alternative but to suspend enrollment in that issuer and wait for it to remediate the problems. The risk of poor performance by issuers could produce a very frustrating/inconsistent consumer experience and call into question the value of the Exchange.

2. Financial

The Exchange is statutorily required to develop the premium billing function for the administration of the small business health options program or SHOP. Although there are some technical elements of a premium billing system unique to the non-group market, such as the need to split bill an invoice between the enrollee share and the APTC amount, an overwhelming percentage of the technical specifications of a premium billing system designed and built for SHOP can be leveraged for the non-group market. (If the Exchange decides to subcontract premium billing and collection for the non-group and SHOP exchanges separately to two different vendors, then this synergy will not exist.) As a result, generally, the financial impact to the Exchange resulting from the implementation of a non-group premium billing system is not as significant as fully developing a new system when synergies with either IT system build or TPA services are fully exploited.

During discussions with systems integrator vendors and or TPAs it is important for the Exchange to gain an understanding of pricing for modifications and customizations that will need to be made to any off the shelf solution that is currently available and also discuss the costs of ongoing maintenance and system changes as regulatory guidance continues to evolve. Having a thorough understanding of the likely costs in this area will allow for a better analysis of true financial impacts of non-group premium billing on the Exchange.

The most significant incremental costs to the Exchange may be invoice generation, postage, and mailing, which are variable costs whether borne by issuers or the exchange. With increasing use of EFT, even these incremental costs can be minimized.

While certain premium billing modifications will most likely need to occur on the carrier side, regardless of whether the Exchange performs premium billing for the non-group market or not, it would seem likely that certain major system enhancements will not need to occur saving the carriers from additional administrative cost. Two examples that meet this criterion are:

- The need to split bill an invoice between the enrollee share and the amount due from Treasury as an APTC, and
- The notifications and tracking of enrollees that are in a non-payment status and within the required grace period.

An additional financial consideration is the reliance of the Exchange on issuers to track user fees: for example, if the Exchange relies on user fees, and if DC allows individuals to enroll outside the exchange – both big "if's"--then unless the HBX does premium billing and collection, it must rely on the issuers to track non-subsidized individual enrollments and "volunteer" user fee payments to the Exchange. Simply defining an individual Exchange enrollee who does not qualify for APTCs becomes problematic unless the Exchange does billing and collections. For example, consider a family that shops on the Exchange, selects its (unsubsidized) QHP, and then calls the issuer to check something and enroll; or consider a family that is enrolled in a QHP for which it receives APTCs, loses eligibility for APTCs and as a result switches from that issuer's Silver plan to its Bronze plan. In the absence of Exchange billing, are these Exchange enrollees? Even if the issuer agrees in principle that they are, the issuer cannot readily identify them as any different from an individual who goes direct to the carrier to enroll.

Moreover, there is a very real cost to the Exchange in terms of additional reconciliations, implementation of oversight controls, and monitoring all with multiple carriers should the Exchange chose not to do individual billing.

3. Ability to Implement Timely

The Exchange is required statutorily to implement a premium billing system for SHOP, so an important consideration is whether including premium billing for the non-group market, which is not statutorily required, will negatively impact the implementation of the SHOP premium billing system.

A key part of this assessment process will start with a detailed discussion with the system integrator (SI) to determine based on the current date what options are still available for the exchange to develop a

fully functioning individual billing system by October 1, 2013. This discussion should be explicit around the functionality the can be developed to meet the District's specific needs. The SI should be able to provide a timeline for development that will help the Exchange weigh the benefits of directing resources to this project verses directing those resources to other key Exchange areas.

Another important element of the assessment is to understand the ability of carriers to implement the necessary changes to their premium billing systems to meet the specifications of the exchange and the ACA, should the exchange decide not to implement a premium billing system for non-group.

If it is determined that both options continue to be viable, at this point in time, the Exchange will need to assess the benefits of redirecting resources from designing and building an individual premium billing system to achieving other operational needs against the challenge of working with multiple carriers to ensure their premium billing systems are exchange and ACA-compliant, and ensuring that the Exchange will have appropriate insight and influence regarding the pace and level of functionality being developed by the carriers.

4. Enrollee Experience

The exchange has the potential to provide one-stop shopping for the purchase of health insurance for eligible individuals and small businesses. Performing the premium billing function would provide enrollees with a seamless consumer experience ranging from the initial eligibility determination process, transitioning to comparison shopping, and culminating in the purchase of an exchange-certified qualified health plan, completing the one-stop shopping experience. An exchange based billing model would also allow for consolidation and simplification of billing (in the form of a single bill) across family units who might select different QHPs or for individuals who might have different plans for health and dental. By developing the capability for non-group premium billing, the exchange can allow an individual to determine its eligibility for premium tax credits and cost sharing subsidies, shop among issuers for level of benefits, provider network and premium, and complete the transaction by providing payment to the exchange via check, money order, debit card, credit card, or ACH/EFT.

The member self-service functionality should allow enrollees to select billing options such as paper or online, and allow member account look-up for outstanding balances, previous payments, transaction history and year-to-date totals. Demographic changes such as address or contact information can be performed on the exchange portal, which will automatically update the billing information in the premium billing system. (Electronic communications is such a critical functionality and cost-saver for both the HBX and the issuer that they should routinely share contact information on their "joint" enrollees as part of the data transfer confirming enrollment and the first month's premium collection.)

Enrollees who move between the exchange and other publicly subsidized programs can be seamlessly added or terminated, with any necessary billing adjustments such as refunds, write-offs, or debit/credits provided within the exchange's premium billing system.

Moreover, a very large portion of the Exchange's customer service calls will be about eligibility determination and billing issues. By integrating the customer call center with the eligibility determination, enrollment, web portal, and premium billing solution, a higher level of customer service can be achieved by the exchange. (On the other hand, a modest amount of customer inquiries

throughout the plan year will entail both premium billing and claims or other health plan issues, in which case handling everything at the plan has some advantages for ease and integration of customer service.)

Reporting

Accurate, timely, and thorough reporting are important statutory requirements of the exchange under the ACA, and will be highly scrutinized by CMS/CCIIO. Whether or not the exchange is performing the premium billing function, its reporting requirements to the federal HUB are substantial:

- The premium(s) for the applicable benchmark plan(s) used to calculate advance credit payments;
- The period the coverage was in effect;
- The total premium for the coverage without the reduction of advance credit payments and consumer cost sharing;
- The aggregate amount of advance credit payments or cost sharing reductions;
- The name, address and Social Security number (SSN) of the primary insured; and
- All information provided to the Exchange at the time of enrollment or during the taxable year, including changes in circumstances.
- Ensure that advance payments of the premium tax credit is provided only to qualified individuals and *assist the IRS* in the reconciliation of these payments

In addition, the exchange in concert with HHS must perform the following:

- Establish a process by which QHPs are notified of enrollment information and reconcile this information with HHS at least on a monthly basis (§155.400).
- Premium payment deadlines must comply with enrollment rules and effective coverage dates.
- A person awaiting determination and administration of the advanced payment of premium tax credit, may obtain enrollment if they pay the entire premium cost for the first partial month of coverage (§155.420(b)(i)(B)).
- The Exchange must ensure that individuals pay their first month's premium to ensure enrollment within either the annual open enrollment period or within 60 days from a triggering event during a special enrollment period (§155.410, §155.420).
- Activities related to the eligibility determination of the premium tax credit must be performed by the Exchange and the Exchange must promptly submit all information related to the application, update, or renewal of this information to HHS (§155.302(c)(2)).

Developing the processes and capabilities to satisfactorily meet these requirements will be demanding for a self-contained, highly functioning premium billing system. Having to orchestrate, compile, and reconcile this information across multiple carriers in a decentralized model, such as when carriers are performing the premium billing function, will likely create a higher level of business risk for the exchange. In addition, the resources required to build data interfaces, ensure data integrity, and reconcile premium billing data resident in carrier systems to enrollment, eligibility and tax credit data housed in exchange systems will be an expensive and potentially time consuming monthly exercise.

5. Oversight & Monitoring

The high level of transparency and audit requirements placed on the exchange by the ACA, and the dependence of issuers on precise premium billing and thorough collections efforts predicate that both the exchange and participating issuers will need strong systems of internal control, management oversight, and ongoing maintenance and monitoring of the premium billing and related systems, regardless of what entity performs premium billing and collections functions.

Developing processes for systems that are internal to the Exchange will be a much easier and a more concise operation for the Exchange. Having to oversee carrier systems from afar, perform regular operational reviews on carriers, and develop processes and protocols for different carriers using different system platforms and differing capabilities can be costly and time-consuming. While an issuer that relies on the Exchange for this core health plan function will need assurances that the premium billing process is accurate and timely, each issuer will simply use its existing controls over billing and will not need to interact with other issuers.

Conclusion

We have provided key considerations to be evaluated when assessing the most appropriate entity to perform non-group premium billing and collections. The most important criterion for judging any option is excellent customer service, accuracy of performance and strong management oversight. Therefore, it is critical to filter these considerations through the lens of the Exchange's near-term capabilities – whether outsourced to a TPA or built for the Exchange and performed internally. It is also important to understand the issuers' capabilities to perform a substantially more challenging billing and collections functions than they currently face in the individual market. It is also important to make this decision soon, and to ensure that issuers are well informed and included in the process, as their system integration, reconciliation, and ultimate buy-in is necessary for the success of any non-group premium billing option that is selected.

Summary of ACA Regulations

Exchange Premium Billing – Responsibilities and Requirements:

The Affordable Care Act specifies that a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the Exchange or to the "health insurance issuer issuing such qualified health plan" (Section 1312). If the Exchange elects to manage the collection of individual premium payments, it may choose to contract the management of this process to a vendor. The approach the Exchange selects regarding how individuals pay their premiums and how issuers receive premium payments will have a significant impact on Exchange members, QHP issuers, and the Exchange itself.

Potential benefits of the Exchange aggregating premiums on behalf of individuals;

- Ease for the consumer by providing a single point of contact for eligibility, enrollment, premium payment status, and problem resolution;
- Consistent source of payments for QHP issuers;
- Increased program integrity;
- Real-time enrollment and payment data for Exchange monitoring;
- Increased ability for the Exchange to address discrepancies;
- Provides greater flexibility in establishing the infrastructure and operations required to process premium payments;
- Allows the Exchange to offset administrative costs; and
- Decreases administrative burden of meeting HHS and IRS reporting requirements.

Financial Oversight and Reporting

The Exchange must keep accurate accounting of all activities, receipts, and expenditures and annually report to the Secretary of HHS. HHS will conduct

annual audits and may investigate the affairs of an Exchange (§155.220(d), Section 1313 of the ACA).

Individual Payment of Premiums

An Exchange may choose to facilitate the electronic collection and payment of premiums (§155.240), but must permit an individual to submit payment directly to the QHP issuer (§155.240(a). HHS encourages the Exchange to allow consumers multiple payment options, such as e-payment and payment through the mail.

The types of activities that need to be performed as part of the collection and payment of premiums, may include;

- calculation of premium payments;
- Issuance of premium payment notices to individuals;
- generate bills;
- manage electronic and paper check premium payments;
- process electronic funds transfer and/or credit card payments;
- collect late payments;
- generate receipts; and
- Terminate for non-payment.

Tribal considerations: The Exchange may permit Indian tribes, tribal organizations, and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals, subject to terms and conditions determined by the Exchange (§155.240(b)).

Required standards: When conducting an electronic transaction with a QHP issuer that involves the payment of premiums or an electronic funds transfer, the Exchange must comply with all the privacy and security rules related to personally identifiable information (§155.260), including; that any personally identifiable health information is always complete, accurate, and up-to-date (§155.260(a)(3)(vi)); that this information is protected with reasonable operational, administrative, and technical safeguards to ensure confidentiality,

integrity, and availability of information (§155.260(a)(4)); and that all electronic transactions must comply with applicable HIPPA and HIT protocols and standards (§155.270).

The Exchange must ensure that any third parties with access to this information have the same or more stringent privacy and security standards (§155.260(b)).

Advanced Payments of the Premium Tax Credit

Activities related to the eligibility determination of the premium tax credit must be performed by the Exchange and the Exchange must promptly submit all information related to the application, update, or renewal of this information to HHS (§155.302(c)(2)). The Exchange must ensure that advance payments of the premium tax credit is provided only to qualified individuals and assist the IRS in the reconciliation of these payments (§155.340(c)). Simultaneously, the Exchange must notify and transmit to a QHP issuer required information so that the issuer can implement, discontinue the implementation, and or modify the level of advance payment of the premium tax credit (§155.340(a)(2)).

The Exchange must provide an individual determined eligible for premium tax credits with a three-month grace period for non-payment, but is allowed to terminate coverage retroactive to the end of the first month of the grace period if no payment is received by then of the 3 month period. The individual does not have an advance payment tax credit for a month where coverage was not provided and is not required to reconcile payments for terminated months without coverage (§156.270).

Information Reporting By Exchanges (IRS §1.36 B-5): Exchange is subject to reporting requirements with respect to information reporting related to premium tax credit. Exchanges are required to report to the IRS taxpayers' information, including:

- The premium(s) for the applicable benchmark plan(s) used to calculate advance credit payments;
- The period the coverage was in effect;
- The total premium for the coverage without the reduction of advance credit payments and consumer cost sharing;
- The aggregate amount of advance credit payments or cost sharing reductions;
- The name, address and Social Security number (SSN) of the primary insured; and
- All information provided to the Exchange at the time of enrollment or during the taxable year, including changes in circumstances.

QHP Enrollment:

The Exchange must ensure that individuals pay their first months premium to ensure enrollment within either the annual open enrollment period or within 60 days from a triggering event during a special enrollment period (§155.410, §155.420).

The Exchange must establish a process by which QHPs are notified of enrollment information and reconcile this information with HHS at least on a monthly bases (§155.400). Premium payment deadlines must comply with enrollment rules and effective coverage dates. A person awaiting determination and administration of the advanced payment of premium tax credit, may obtain enrollment if they pay the entire premium cost for the first partial month of coverage (§155.420(b)(i)(B)).

Termination: The Exchange is allowed to terminate enrollment in a QHP for non-payment of premiums (§155.430). The Exchange must establish a process to transmit termination information to QHP issuers and HHS (§155.430). In instances of termination due to non-payment of premiums, the 90-day grace period for individuals receiving advance payments of the premium tax credits or other grace periods afforded to individuals not receiving tax credits must be exhausted.

SHOP

The SHOP must aggregate premiums on behalf of the employer. The Exchange must provide an employer with a monthly bill identifying the total amount due to QHP issuers, the employer contribution, and the employee contribution. The SHOP will collect the amount due from employers and make payments to QHP issuers (§155.705(b)(4)).

SHOPs must maintain certain records and other evidence of accounting procedures and practices related to premium aggregation for at least 10 years. This recordkeeping requirement was added to the final regulations for purposes of conforming to individual Exchange standards. The SHOP must also retain records for 10 years, and report employer participation and employee enrollment to the IRS for tax administration purposes (§155.720).

Qualified individual enrolled in qualified health plan may pay applicable premium owed to the health insurance issuer issuing such qualified health plan	Section 1312(b)
Exchange must keep accurate accounting of all *activities*, receipts, and expenditures and annually report to Secretary of HHS	Section 1313; §155.220(d)
Exchange may choose to facilitate the electronic collection and payment of premiums	§155.240
Must permit an individual to *submit payment* directly to the QHP Issuer	§155.240(a)
Exchange may permit Indian tribes, Tribal organizations, and urban Indian organizations to submit aggregated premiums on behalf of qualified individuals	§155.240(b)
The Exchange may only use or disclose personally identifiable information to the extent such information is necessary	§155.260
Must ensure that personally identifiable information is complete, accurate, and up-to-date	§155.260(a)(3)(vi)
Must establish and implement safeguards to ensure confidentiality, integrity, and availability of information	§155.260(a)(4)
Exchange must ensure that all transactions comply with applicable HIPPA and HIT protocols and	§155.270

standards	
Must ensure that any third party with access to personally identifiable information have the same or more stringent privacy and security standards	§155.260(b)
Exchange must transmit all information related to an application for eligibility determination to HHS	§155.302(c)(2)
Exchange must provide information related to the reconciliation of advance payments of premium tax credit	§155.340(c)
Exchange must notify and transmit information needed for the issuer to implement, discontinue, or modify the level of advance payment of the premium tax credit	§155.340(a)(2)
The Exchange must provide an initial open enrollment period from 10/1/2013 through 3/31/2014 and abide by coverage effective dates	§155.410
Exchange must provide special enrollment periods in the case of a qualifying event	§155.420
A qualified individual who pays the entire premium for the first partial month of coverage, while awaiting for administration of the advanced payment of premium tax credit, may be enrolled through the Exchange	§155.420(b)(1)(i)(B)
Exchange is allowed to terminate enrollment in a QHP for non-payment of premiums and must submit termination information to the QHP issuer and HHS	§155.430
SHOP must: • Provide employer with a monthly bill detailing total due, employee and employer contribution • Collect total amount due from employers • Maintain records and evidence of accounting related to premium aggregation for 10 years.	§155.705(b)(4)
SHOP must report employer participation and employee enrollment to the IRS	§155.720

DC Exchange Premium Billing Work Group Meeting

February 7th, 2013 Meeting Takeaways

Workgroup Objective: To make a recommendation to Exchange management and the Board regarding Exchange performance of premium billing and collections functions for the individual (non-group) market.

Options currently available:

1. The DC exchange will contract to build and operate a premium billing capability for the non-group market. Note: This system would not preclude individuals making payments directly to the carriers.
2. The DC exchange will not build the capability to perform premium billing and collections for the non-group market. (Carriers would be required to perform all billing and collections functions.)
3. The DC exchange could build a hybrid model of premium billing for the non-group market. For example:
    a. Exchange could set up a model similar to MD to perform only initial billing and collection.
    b. Exchange could set up a model to assist in billing for only certain types of carriers such as dental carriers (which would likely be lower volume from a mailing and collection standpoint than health carriers).

Discussion Points:

Main Carrier Points:

- Key concern of carriers is that the exchange will not be capable of getting everything up and running (in an appropriate manner) by the Oct. 1 deadline.
- Carriers also point out that they already have this capability as part of their business model and as such to have exchange perform could be duplicative, unnecessarily expensive, and confusing to consumers.
- Carriers (those represented in person and on the phone) believe that they are capable of getting all needed changes to their systems in place by the Oct. 1 deadline.

Main Consumer Advocate Points

- Key concerns of consumer advocates are that if the exchange does not perform at least initial collection of payment many customers could be lost or dropped in the transition to the carriers, and therefore not get coverage. This concern is perhaps highlighted by the understanding that many insurance carriers do not currently appear to have facilities to handle walk in payments.
- Another concern among consumer advocates is that the reconciliation aspects of enrollment in plans will be very difficult to manage if the exchange does not perform billing and collections functions. For example: timing of communications and reconciliations between carriers and exchange will have to be much more frequent and seamless as the carriers will still want to view

the exchange as the record of truth/source and yet the exchange will at times be receiving secondary information from those carriers. Slow timing on communications from carriers could lead to in accurate reporting between the exchange and the federal HUB and the general ability of the exchange to provide appropriate information. For example: If someone calls the exchange call center to discuss enrollment status the exchange system may not be as up to date as the carrier system. (Whichever party does the billing, communications between exchange and carriers must be rapid, frequent and accurate.)

- Finally, transparency from the exchange and protection for the potential exchange members is key and therefore, carriers would have to come to agreements with the exchange that would standardize many policies and procedures across the plans to ensure that the consumer experience is more uniformed and easier for members to understand.

Main Exchange Staffing Points:

- The potential vendor for this project had originally bid to build premium billing and collections capabilities for both individual and SHOP enrollees by the Oct. 1 deadline; however, the staff are mindful that this would require more of their already over stretched resources and that there have been some delays, so the vendor's capacity is worth checking as a threshold question.
- The exchange staff understand that regardless of the decision that is made there are still many policies and procedures that must be worked out and put in place and as such a decision to have carriers perform billing and collections would not entirely relieve the exchange of cost and obligation. (Even if the exchange has the carriers perform this function there will still be an element of oversight and quality assurance that the exchange must perform in order to comply with reporting and transparency requirements as well as its general mission in providing access to health insurance coverage.)

Action Items:

- Confirm with the vendor that the timeline for the exchange to set up a premium billing function is still possible.
- Obtain estimate from the vendor of incremental operating cost of the Exchange performing individual billing
- Query dental carriers about their capabilities to perform individual premium billing and collections functions (would this be a limiting factor for certain groups to participate in the exchange).
- Develop a written description of the hand-offs and likely obstacles to a smooth end-to-end customer service experience for enrollment and premium billing, and ask the health plans (proposing to handle individual billing exclusively) how these challenges can be handled when the Exchange handles shopping and plan selection, while the plans do the billing and collection. Schedule rest of the working group meetings.

DC Exchange Premium Billing Work Group Meeting

February 20th, 2013 Meeting Takeaways

Workgroup Objective: To make a recommendation to Exchange management and the Board regarding Exchange performance of premium billing and collections functions for the individual (non-group) market.

Options currently available:

1. The DC exchange will contract to build and operate a premium billing capability for the non-group market. Note: This system would not preclude individuals making payments directly to the carriers.
2. The DC exchange will not build the capability to perform premium billing and collections for the non-group market. (Carriers would be required to perform all billing and collections functions.)
3. The DC exchange could build a hybrid model of premium billing for the non-group market. For example:
    a. Exchange could set up a model similar to MD to perform only initial billing and collection.
    b. Exchange could set up a model to assist in billing for only certain types of carriers such as dental carriers (which would likely be lower volume from a mailing and collection standpoint than health carriers).

Key Discussion Points:

- Recap of prior meeting points was provided.
- Carriers reiterated that they feel that their existing standalone systems and procedures are capable of being modified to meet all individual billing.
- Various consumer considerations were raised. Examples are as follows:
    - If carriers perform all billing functions how/when will Exchange hand-off individuals to carriers during initial enrollment process?
    - Carrier due dates may not be uniformed and thus could cause confusion for consumers and the exchange (Carriers noted that they would like be open to discussion of standardization on timing requirements).
    - How can reconciliation between Exchange records and Carrier records (particularly for initial enrollment) be facilitated in a real-time manner?
    - Would exchange members be charged penalties for late payments to carriers?
    - Exchange would have to closely monitor each carrier's application of grace periods and terminations for non-payment.
    - It seems that the types of payments (multiple sources, multiple times per month, etc) might be more complicated than what carriers have traditionally dealt with in the individual market and as such the exchange would need assurance that customer service would not suffer in the event of these complications.

    - If a family were to choose multiple carriers for different family members or perhaps standalone dental coverage the individual would be responsible for making payments to multiple groups each month. This seems like it could be complicated for the individuals.
- Carrier representatives pointed out the following:
    - Their relationship with a customer is facilitated and grown through regular customer contact during the billing process so they see this regular contact as valuable.
    - Individuals receiving billings from multiple sources is already a reality in today's market and as such should not be overly burdensome to individuals who are familiar with this system.
    - Carriers continue to have concerns about the Exchange's ability to have this system fully operational and well controlled by October 1, 2013.
    - Many carriers in this area operate in other states such as MD and as such are already developing systems and controls to handle the hybrid approach chosen by MD.
- Benaissance Presentation:
    - This decision is an important decision point for the Exchange and concern by both the Exchange and the carriers is natural as this discussion is regarding who touches the cash flow.
    - Benaissance currently works with over 70 carriers, TPA service providers, COBRA administrators, and retirement groups to administer premium billing services.
    - The Benaissance solution would allow for consolidated billing for households and as such would eliminate the issue of households receiving bills from various sources.
    - Initial payment issue is on that is a concern for all states that have elected to have carriers perform all billing functions (including initial enrollment billing).
    - Of the current Benaissance individual population 81% are paper based and it is estimated that 40% of payments receive do not contain payment coupons. (This statistic/payment demographic could be new to existing carrier systems.)
    - The unbanked and underbanked population in DC is approximately 36%.
    - An example was given about VT and unique way they chose to solve the question/issue with federal guidance requiring that individuals have the right to pay carriers directly.
- Other Considerations:
    - It was pointed out that the DC government does not have a proven track record around billing and collection processes and as such building/improving public perception and public trust will be key regardless of what decision is made. Protection of assets is key.
    - Consumer advocate groups noted that the new individual population coming into this insurance market will likely need good access information/counseling regarding their ability to make payments in full each month and this would be most effective when provided by individuals who are knowledgeable about various social service and social assistance programs. This was brought up as carriers would not be able to provide that level of counseling.

    - Finally cost considerations must be nailed down. The cost for the Exchange to build and maintain the system must be weighed against the benefits of the exchange performing this service.
- Action Items:
    - Bonnie to obtain cost information from vendor.
    - Wakely to help organize and facilitate next meeting in a way that drives group to a decision point and hopefully consensus on this topic.

Notes from DCAS Premium Billing and Collections Call

Date: February 8, 2013

Attendants:

Bonnie Norton: DC Exchange
Gregg Kramer: Infosys
Vikram Kodipelli: Benaissance
Jon Kingsdale: Wakely Consulting
Patrick Holland: Wakely Consulting
Diana Galatian: Wakely Consulting

Key Takeaways

- Benaissance states that it currently has the capabilities to build out a premium billing and collections solution and provide ongoing administration of the billings and collections for the non-group market in DC on time for pilot/testing in September (in addition to the existing work on the SHOP).
- As evidence of its capabilities, Benaissance does premium billing now for some corporate 70 clients, mostly in the COBRA and retiree space, so is quite familiar with individual billing, and is also building and will operate individual billing for Vermont.
- The addition of individual premium billing and collections capabilities would not negatively impact the existing (required) SHOP design and implementation schedule.
- The decision to add individual billing to the existing work order/work plan is time sensitive. The recommndation would need to be made by the end of February with final Board approval to move forward with the project by early March.
- Benaissance currently has an existing banking relationship to provide cash management services; however, Benaissance is flexible should the exchange need to use either DC government banking relationships or at least local DC banking institutions.
- Bonnie will provide Benaissance with updated information and, in turn, Benaissance will be able to update their pricing estimates for the exchange to show cost of both building the individual capabilities within the premium billing system and operational costs going forward.