America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

January 7, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9930-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Patient Protection and Affordable Care Act; Exchange Program Integrity—AHIP Comments

Dear Administrator Verma:

On behalf of America's Health Insurance Plans (AHIP), thank you for the opportunity to offer comments in response to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Exchange Program Integrity Proposed Rule, published in the *Federal Register* on November 9, 2018.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We believe all Americans should have access to affordable, comprehensive coverage.

Americans deserve a stable, competitive individual market to ensure those who don't have coverage through their workplace or qualify for Medicare, Medicaid, or other programs have access to affordable, quality coverage. We support rules that ensure exchanges are stable, operate efficiently and effectively, and encourage consumers to get covered. Health insurance providers are committed to integrity, accuracy, and accountability as they deliver health care for Americans. To advance these goals, we support:

- Proposed changes to authorize access to additional data sources so Exchanges can verify a consumer's eligibility for coverage, and
- Expanding the scope and frequency of periodic data matching (PDM) for all Exchanges.

At the same time, we have serious concerns with any proposals that create a more complex and confusing consumer experience, impose new costs on consumers, and could increase premiums by imposing new costs on health insurance providers. These factors together could result in

enrollees losing or going without the financial security coverage offers. As a result, we strongly oppose the proposed requirement that health insurance providers send separate bills and collect separate payments for the portion of the monthly premium attributable to coverage of non-Hyde services.

CMS proposes to require that health insurance providers send two separate bills and collect two separate payments to satisfy the monthly premium for a single policy. Bifurcating the premium payment process in this manner would not enhance exchange program integrity with respect to transparency or appropriate use of federal funds. Health insurance providers already notify consumers when non-Hyde services are covered through the summary of benefits and coverage (SBC) at the time of enrollment. Health insurance providers follow existing federal guidance to notify consumers of the segregation of funds requirement and separate payments to ensure advance payments of the premium tax credit (APTCs) are not used to pay for non-Hyde services. The proposed requirement would also directly conflict with Executive Order 13765, issued by the President on January 20, 2017, directing Federal agencies to identify and alleviate regulatory burdens related to the Affordable Care Act. We urge CMS to retain the existing requirements, which promote transparency and ensure segregation of funds while mitigating additional complexity and costs for consumers and issuers.

For the millions of people who would receive separate bills for a single policy and be required to pay their premium via two transactions, this rule would generate unnecessary confusion and frustration, make it more difficult for them to pay their premium bills, and could result in coverage being terminated for non-payment. Consumers would incur ancillary costs that would further drive up administrative costs and burden, including postage costs, money order fees, or other banking fees. Issuers would be required to consider administrative costs when setting actuarially sound rates, which could lead to higher premiums for consumers.

In a recent survey of Americans who buy individual market coverage, respondents strongly supported decreasing the costs and complexity of health insurance. In partnership with AHIP, Morning Consult conducted a survey of over 1,000 Americans who buy their own health insurance.[1] The majority opposed the proposed requirement for separate billing and collection of payments. The survey found:

- 95 percent think health insurers should make health care administration simpler, easier, and more efficient.
- 93 percent think the government should enact regulations that make the cost of health insurance lower, with support for simpler health care administration spanning political parties.
- 2 in 3 opposed the requirement for two separate bills.

[1] Morning Consult survey conducted on behalf of AHIP, 1044 registered voters, December 13-26, 2018, MoE +/- 3%.

- 89 percent say making two separate payments for their monthly premium would be a burden.

We provide additional findings from this survey in our detailed comments and Appendix A.

When health insurance providers develop coverage offerings, they must comply with state and federal laws, including state mandates and benchmark benefits. They also consider benefits they deem important to providing comprehensive coverage and are attractive products that consumers want to buy. The result is a set of benefits that together provides comprehensive coverage. The proposed requirement to bifurcate the billing and payment process for a single policy would create two barriers to the development of comprehensive benefit packages. First, it would place an overly burdensome requirement on health insurance providers who are required to include certain mandated services, or who voluntarily do so in an effort to provide comprehensive coverage. Second, separate billing and payments for a single policy would create the misperception that health insurance coverage may be obtained by selecting from a menu of benefits and services.

There is no other health care benefit or service, under a single medical policy, for which the portion of the premium attributable to that service is billed separately. To ensure health coverage markets work efficiently and are affordable for everyone, including people with pre-existing medical conditions, consumers purchase a *package* of medical benefits—rather than selectively picking and choosing which services they want to pay for. For example, when issuers cover substance use disorder treatment, whether due to a mandate or voluntarily, consumers do not have the option pay only a portion of the premium because they do not use—or expect to use—those services. If consumers were able to selectively purchase only benefits and services they knew they would use, the associated premiums for those coverage products would quickly become unaffordable due to adverse selection.

Separate billing and payments for a single policy would create substantial new administrative costs for health insurance providers and, subsequently, for the consumers they serve. AHIP conducted a survey of our member health plans to solicit feedback on the potential costs and operations burden for health insurance providers required to comply with the proposed requirement.[2] We received 19 responses. Ten of those respondents would be required to comply with the requirements. They estimated:

- Approximately **2.4 million of their enrollees** would be affected.[3]

[2] We received 19 responses. Ten respondents would be required to comply with the requirements based upon their current coverage offerings and estimated the costs, operations burden, and time to comply with the proposed requirements. The other nine respondents estimated the potential operations burden and timing if they were required to comply in the future, for example due to a new State mandate.

[3] These ten respondents do not represent all health insurance providers who would be required to comply. Thus, the number of affected consumers would be greater than 2.4 million.

- Costs for initial system changes to comply with separate billing and payment requirements would range from **$50,000 to $7.5 million per issuer**.
- Annual costs to comply with separate billing and payment requirements ranging from **about $70,000 to about $10.8 million per issuer**.

We provide additional findings from this survey in our detailed comments and Appendix B.

These figures far exceed CMS' estimate of the proposed information collection requirement burden, and suggest that the regulatory analysis does not provide a comprehensive evaluation of the key effects—quantitative and qualitative—of the proposed requirement. OMB guidance to agencies included in OMB Circular A-4 generally requires that the benefits of any proposed rulemaking exceed the costs. [4] Given the incomplete analysis of the proposed rule's expected cost and benefits, the Agency cannot accurately determine whether the benefits outweigh the quantitative and qualitative costs to justify finalizing the proposed regulation.

AHIP and its members strongly believe we need to strengthen the individual market to provide the American people affordable, high-quality health care. Because of the additional burden and costs for Americans, we strongly oppose separate billing and urge CMS not to finalize this new regulatory requirement. We appreciate the opportunity to submit comments on this matter. If you have additional questions, please contact Kelley Turek at kturek@ahip.org or 202-861-1459.

Sincerely,

Jeanette Thornton
Senior Vice President, Product, Employer and Commercial Policy

[4] Office of Management and Budget. Circular A-4. September 17, 2003.

Detailed Comments on the Exchange Program Integrity Proposed Rule

Our detailed comments on the CMS Exchange Program Integrity proposed rule are organized into the following sections:

- **I. Verification Process Related to Eligibility for Insurance Affordability Programs**
- **II. Eligibility Redetermination During a Benefit Year**
- **III. Segregation of Funds**

I. Verification Process Related to Eligibility for Insurance Affordability Programs (§155.320)

CMS proposes to expand current processes to verify eligibility for Exchange enrollment and other insurance affordability programs. Specifically, CMS proposes to add a new authorization to the Federal marketplace eligibility application so unsubsidized enrollees may allow the exchange to terminate qualified health plan (QHP) coverage if they are found to be dually enrolled in Medicare. Currently, this optional authorization is only available to subsidized enrollees.

Recommendations:

- **We support expanding the current PDM processes to reduce the number of consumers who are dually enrolled in coverage through the Marketplace and other public programs.** We have previously raised concerns about enrollees who are eligible for or enrolled in other public programs who enroll in coverage through the Marketplace instead of—or in addition to—public program coverage. To promote a stable risk pool and affordable premiums, consumers should enroll in coverage designed to fit their needs. When enrollees who are eligible for other programs, specifically for Medicare, enroll in Marketplace coverage, this can drive up premium costs for all enrollees. Thus, we support expanding the current Federal Marketplace application authorization to verify Medicare enrollment and terminate QHP coverage in the case of dual enrollment.

II. Eligibility Redetermination During a Benefit Year (§155.330)

CMS further proposes to require that exchanges, including the Federally-facilitated Marketplace (FFM) and State-based Marketplace (SBM) states, conduct Medicare, Medicaid/CHIP, and Basic Health Plan (BHP) periodic data matching (PDM) twice per year beginning in calendar year 2020.

Recommendations:

- **We support the requirement that all Exchanges conduct PDM for Medicare, Medicaid, and the Basic Health Plan (if applicable) at least twice a year.** Currently, the FFM conducts Medicaid/CHIP PDM twice annually and recently began conducting Medicare PDM, though the authorization that permits the FFM to terminate QHP coverage for subsidized dual enrollees is relatively new. We support all Exchanges conducting PDM twice annually and terminating coverage for dually enrolled consumers. This process is helpful in identifying consumers who may have enrolled in another public program mid-year, for example when a consumer turns 65 and enrolls in Medicare mid-year but forgets to terminate Marketplace coverage. Especially when conducted prior to the annual batch auto reenrollment (BAR) process, PDM can help ensure these dual enrollments do not persist into the next plan year.

- **We recommend CMS provide State-based Marketplaces a longer timeframe to implement Medicare PDM and, for those SBMs that do not have an integrated eligibility system, Medicaid PDM.** We strongly support CMS in requiring these processes for SBMs to promote consistency and program integrity across all states, regardless of exchange type. However, SBMs may need a longer implementation timeframe to make system changes to support Medicare PDM and, for those that do not have integrated eligibility systems, Medicaid or BHP PDM. SBMs that do not currently conduct PDM or do not have integrated systems would have to make significant system changes to access other State eligibility information to support verification across their Marketplace and Medicaid eligibility systems. All SBMs would need to make system changes and set up new processes to access Federal data sources to verify Medicare eligibility or enrollment status. SBMs would need to implement new processes to authorize access to this data, notify enrollees when dual enrollment is detected, and process terminations for dually enrolled consumers. Thus, we recommend CMS provide SBMs additional time, until calendar year 2021, to comply with the requirement to conduct PDM twice annually.

III. Segregation of Funds (§156.280)

Section 1303 of the ACA set forth certain notice and billing requirements to ensure federal funds are not used to pay for services prohibited by the Hyde amendment ("non-Hyde services"). Issuers are required to collect separate payments in order to segregate funds and notify consumers about coverage of non-Hyde services in the Summary of Benefits and Coverage (SBC) at time of enrollment. In the 2016 Notice of Benefit and Payment Parameters, CMS provided several options for QHP issuers to ensure segregation of funds while mitigating operations costs for issuers and simplifying the process for consumers.

CMS now proposes to require QHP issuers providing non-Hyde services send each policy subscriber an entirely separate monthly bill for the portion of the premium attributable to non-Hyde services and instruct the policyholder to pay the portion of the premium attributable to coverage for these services in a separate transaction from the payment the policyholder makes for the portion of the premium for coverage of all other services. In effect, consumers would receive two bills and be required to make two payments to satisfy the premium of a single policy every month.

Recommendations:

- **We strongly oppose the proposed requirement that QHP issuers split the premium into two monthly invoices—one bill for at least $1 per member per month (PMPM)** [5] **for the portion of the premium attributable to non-Hyde services—and collect multiple payments to satisfy the premium for a single policy. This requirement would not increase transparency or compliance with segregation of funds requirements.** CMS states this requirement would promote transparency for consumers and ensure Federal funds are not used to pay for coverage of these services. Issuers already attest to compliance with notice and segregation of funds requirements under 45 CFR Part 156.280 as part of QHP certification, and exchanges have the oversight authority to monitor this compliance and conduct audits of QHP issuers. Issuers that provide coverage for non-Hyde services are required to notify consumers at time of enrollment via the summary of benefits and coverage (SBC). Issuers follow existing guidance to notify consumers of the segregation of funds requirement and segregate payments in a manner that ensures federal funds are not used for non-Hyde services. The proposed requirement to send two bills and collect two payments for a single policy would not further promote transparency or segregation of funds. Instead, the proposed requirements would create substantial new regulatory burdens for both QHP issuers and consumers, without increasing program integrity.

- **We oppose regulatory requirements that create significant administrative costs, effectively penalizing issuers for complying with State mandates or benchmark benefit requirements. Even absent mandates, issuers should not be penalized for providing comprehensive coverage to consumers.** QHP issuers design product offerings that comply with federal laws and state mandates and provide comprehensive coverage to consumers. The majority of QHP issuers that would be subject to the proposed requirement cover non-Hyde services in compliance with State mandates or to meet benchmark plan benefit requirements. Particularly in the four states that mandate coverage of non-Hyde services—CA, NY, OR, and WA—this would create an onerous new requirement for all QHP issuers and consumers. QHP issuers in those states that find

[5] Under Section 1303 of the ACA issuers may not estimate the actuarial value of coverage for non-Hyde services at less than $1 PMPM. Thus, issuers must charge *at least* $1 PMPM and it is possible that some issuers may charge a higher amount based on their estimate of the actuarial value of those services.

the proposed requirements overly burdensome would not have an option to end coverage of non-Hyde services. Finally, issuers would be required to consider the administrative costs of separate billing when setting actuarially sound rates, which could result in higher premiums.

- **We recommend CMS not finalize the proposed requirement as it would greatly increase regulatory burden and impose unnecessary new costs on consumers and QHP issuers.** In a survey of AHIP member health plans, we found the burden and costs associated with the proposed rule would be much greater than those estimated by CMS. Additional details of the anticipated administrative costs and consumer impact below. AHIP's survey found most issuers would need 12-18 months to implement changes to comply with the requirement and that separate billing and payment could only be implemented at the beginning of a plan year.

Burden and Costs for Consumers Enrolled in Affected QHPs

Consumers who receive two monthly bills and are required to make two separate payments to satisfy the premium for a single policy would likely be confused and frustrated by the new requirement, face new challenges in paying their monthly premium, and incur new costs. We believe CMS seriously underestimated the consumer impact, both with respect to the number of consumers affected as well as the burden and direct costs to consumers.

CMS estimates 1.3 million consumers across all affected QHPs, in all 50 states and the District of Columbia, would be impacted. By comparison, ten respondents to AHIP's survey who would be required to comply estimated approximately 2.4 million of their enrollees would receive separate bills and be required to submit separate payments. AHIP's survey does not reflect the covered lives of all issuers that would be affected by this requirement. In the four states that require coverage of non-Hyde services (CA, NY, OR, and WA), nearly 2.2 million consumers are enrolled in Marketplace QHPs, 1.7 million of whom receive APTC and would receive separate bills under the proposed rule.[6] Additional consumers enrolled in affected QHPs in the 11 states that neither ban nor require non-Hyde coverage, in which at least one issuer provide these services (CO, CT, DC, MA, MD, ME, MT, NH, NJ, RI, VT)[7] would also be impacted.

In partnership with AHIP, Morning Consult conducted a survey of over 1,000 adults—spanning age groups, genders, religious beliefs, and political affiliations—to understand how people might react to the proposed requirement for separate billing.[8] Survey respondents strongly value simplifying health insurance and lowering costs. Ninety-five percent think health insurance

[6] CMS 2018 Open Enrollment State-Level Period Public Use File
[7] Kaiser Family Foundation. Abortion Coverage in the ACA Marketplace: The Impact of Proposed Rules for Consumers, Insurers, and Regulators. Figure 1: Availability of Abortion Coverage through Marketplace Plans, 2019. December 21, 2018.
[8] Morning Consult survey conducted on behalf of AHIP, 1044 registered voters, December 13-26, 2018, MoE +/- 3%.

providers should make health care simpler, easier, and more efficient. Ninety-three percent think the federal government should enact regulations that make the cost of health insurance lower. When asked about the impact of separate billing and separate payments, 89 percent think paying two premium bills each month would be a burden. Survey respondents were also worried about increases in their health insurance costs. For two in three survey respondents, the cost of health care is already too high and for 88 percent, an increase in premiums would have an impact on their family's ability to afford health care. Sixty-six percent of respondents opposed a regulation requiring health insurance providers to send two monthly premium bills, one for the majority coverage and one for a specific benefit like abortion coverage. Additional findings from this survey are in Appendix A.

We expect consumers would be confused and frustrated when they begin receiving two bills for the same policy every month and are required to pay their premium through two separate transactions. Despite issuer notices and communications to explain the second invoice and separate payment requirement are due to federal rules, consumers will likely not understand this change in billing or how this second bill ensures federal funds will not be used for coverage of non-Hyde services. There is no other health care service, under a single medical policy, for which the portion of the premium attributable to that service is separately invoiced every month. Consumers who suddenly begin receiving a second bill may think the bill was sent in error, that the additional $1 is a new charge, that it is an explanation of provider claims like an explanation of benefits (EOB), or that they do not have to pay if they do not use that service.

Sending consumers two bills and requiring they make two payments for a single policy would be an abrasive consumer experience. Based on issuers' prior experiences working with consumers on complex enrollment and payment issues—through their call centers, health insurance casework system (HICS) cases, and department of insurance (DOI) cases—consumers are unlikely to understand or believe the separate invoice is federally mandated or understand its purpose. Consumers will be confused and aggravated by the additional burden of interpreting two invoices and making multiple payments. It would also place additional costs on enrollees. Consumers would incur costs to send separate payments, including additional postage fees up to 55 percent of the amount of the $1 PMPM payment amount for the second payment,[9] fees to send two money orders, or banking fees. Consumers who currently pay via credit card may no longer have this option—issuers incur fees for each credit card transaction and these fees would double, likely causing the issuer to stop offering this option. Consumers who make automatic payments would need to arrange for a second withdrawal and may encounter problems and additional fees if the second, small $1 payment is flagged or rejected as potentially fraudulent.

Some consumers may make a combined premium payment. Per the preamble, the issuer must then notify the enrollee (incurring additional printing, postage, or email costs) that they must make two separate monthly payments in the future to comply with the federal rules. Consumers

[9] In 2019, USPS will increase the cost for first-class mail postage to $0.55.

who do not pay the $1 PMPM bill—whether because they are confused and do not understand they need to pay two bills, or because they elect not to pay for those services—would be at risk for loss of coverage due to non-payment of premium if they do not satisfy the issuer's premium payment threshold.[10] We are concerned this requirement could have a discriminatory impact. Consumers receiving higher premium tax credits would have greater difficulty in meeting the issuer's premium payment threshold. These enrollees are the most financially vulnerable and would be more susceptible to termination due to non-payment. Whereas consumers receiving less premium tax credit assistance could forego paying the $1 PMPM bill, whether intentional or not, and still be within the premium payment tolerance.

Administrative Costs for QHP Issuers
Sending two monthly bills and requiring consumers to make two separate payments to satisfy the premium for a single policy would result in costly new administrative burdens for QHP issuers. Issuers would incur one-time implementation costs to make system changes to support multiple bills for a policy and automate processes to reconcile multiple payments. Issuers would also incur significant monthly costs to identify impacted enrollees, generate and send multiple bills, intake and reconcile monthly payments, and support an increased number of enrollees who fall into the grace period for non-payment of premiums.

The operations impact and administrative costs to generate two monthly bills and collect two separate payments to satisfy the premium for a single policy would be far-reaching. Issuers would need to make significant changes to their enrollment and payment systems to support separate payments:

- Nearly every aspect of the enrollment and billing processes would need to be changed to identify impacted enrollees, generate and send multiple accurate invoices, collect multiple payments, and reconcile payment amounts.
- Issuers would need to implement multiple new notice processes and enhance their customer support channels to educate consumers on the new requirement, address questions and complaints, help enrollees make multiple payments, and notify consumers who combined payments they must pay separately in the future.
- Consumers who do not pay the $1 PMPM invoice for coverage of non-Hyde services could trigger the three-month grace period for non-payment depending on the issuer's premium payment threshold. While grace period and non-payment termination processes are already in place, issuers could face additional costs to support a higher volume of enrollees in these processes.

We provide a detailed list of the impacted processes in Appendix B.

[10] 45 CFR 155.400(g) provides QHP issuers the flexibility to establish a premium payment threshold policy, under which the enrollee can be considered to have paid all premium amounts owed if they pay a set percentage of the total premium owed or the amount owed is less than a set dollar amount established by the issuer.

Based on the results of AHIP's survey, we believe CMS vastly underestimates both the operations burden and new costs to send two monthly bills and collect and two payments to satisfy a the premium for a single policy. CMS anticipates affected QHP issuers would need to make one-time changes to implement functionality to automate billing and payment processing, estimated to cost $841.60 per issuer. Based on the responses to AHIP's survey, actual one-time implementation costs would far exceed this projection. Survey respondents estimated one-time implementation costs ranging from $50,000 to $7.5 million per issuer. CMS anticipates issuers would incur monthly costs for manual work related to preparing and sending separate bills and processing separate payments, totaling $1,452.44 annually for each affected QHP. Respondents to AHIP's survey estimated actual annual costs would range from about $70,000 to $10.8 million per QHP issuer. Appendix B provides detailed estimates submitted by survey respondents (Table 1) and compares CMS' burden estimates with the responses to AHIP's survey (Table 2).

CMS proposes the requirement for separate billing and payments would be effective upon the effective date of the final rule, which can be reasonably expected during 2019. In our survey, we asked issuers how long it would take to implement the necessary changes to support separate billing and payments. Eighty-nine percent of respondents estimated it would take at least 12 months to implement these changes while 67 percent responded it would take at least 18 months. These implementation timeframes assume final, detailed requirements have already been published. Table 3 in Appendix B provides additional details on the estimated implementation timeframe. Importantly, survey respondents emphasized that implementation must be timed to align with the start of a plan year. Issuer billing and payment requirements are typically included in plan documents that are approved by the state regulator and provided to the enrollee at the time of enrollment. A change in payment policies would likely need to be approved by state regulators and could not be implemented mid-plan year.

Administrative Costs for Exchanges

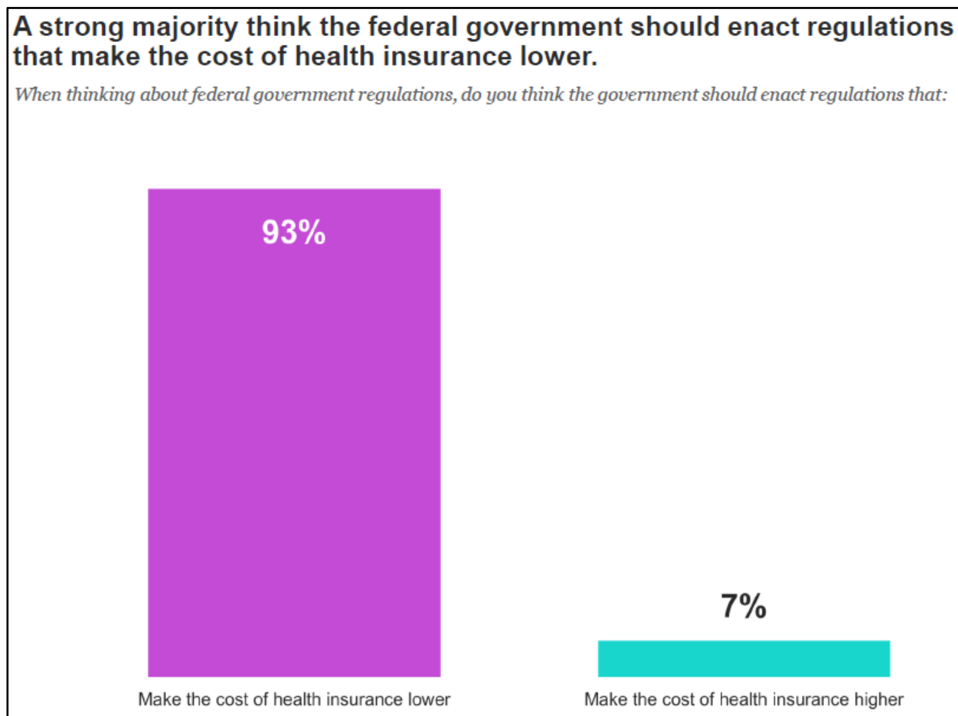
Exchanges—both the FFM and SBMs—would likely be need to make changes to their websites, enrollment systems, and customer service to align with the separate billing and payment requirements. Specifically, we anticipate exchanges would need to:

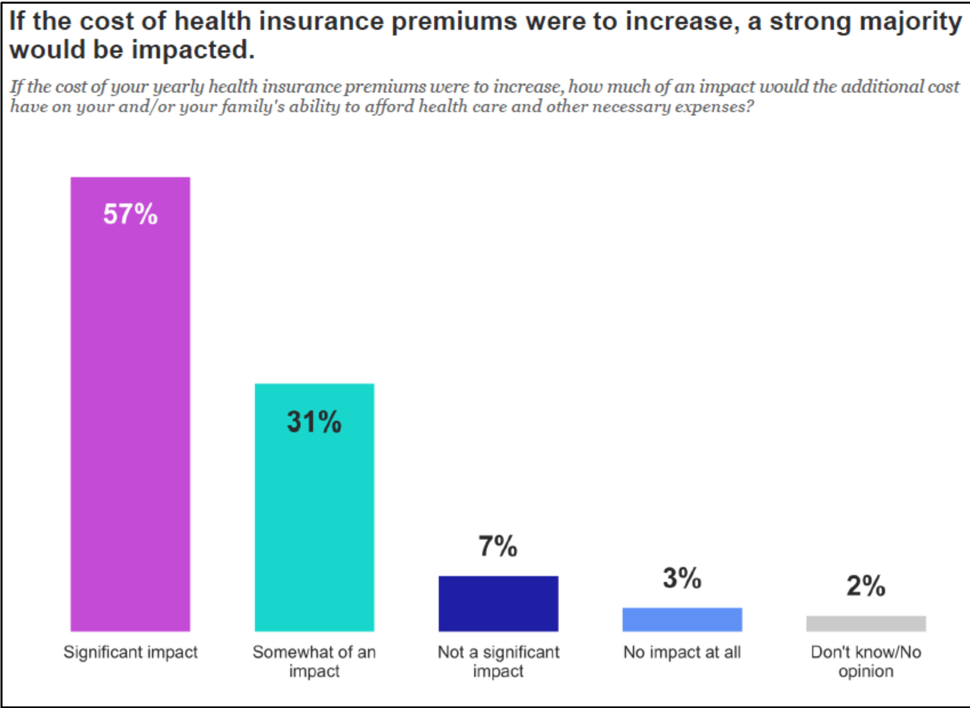
- Communicate the new separate billing and payment requirement to consumers during the enrollment process;
- Update the online payment portal (the "Pay Now" button on healthcare.gov) to collect the binder payment through two separate transactions;
- Update enrollment materials and notices that reference binder payment requirements to effectuate coverage;
- Update call center scripting and customer service to address questions related to separate billing and payment (while questions related to payments should be referred to the issuer, the call center should be prepared to answer questions about why consumers are required to make multiple payments); and
- Update complaint processes (e.g., HICS in the FFM) to address complaints and questions related to separate bills and payments.

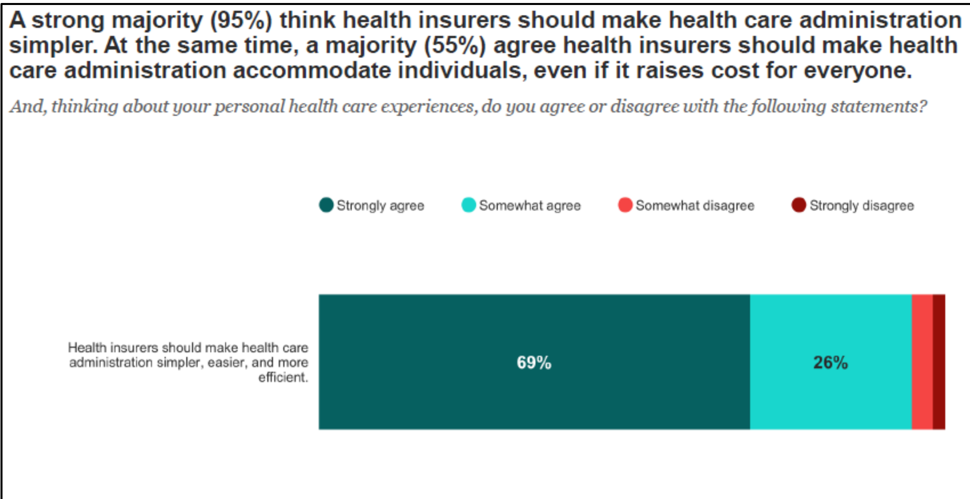
Appendix A: Findings from AHIP-Morning Consult Consumer Survey

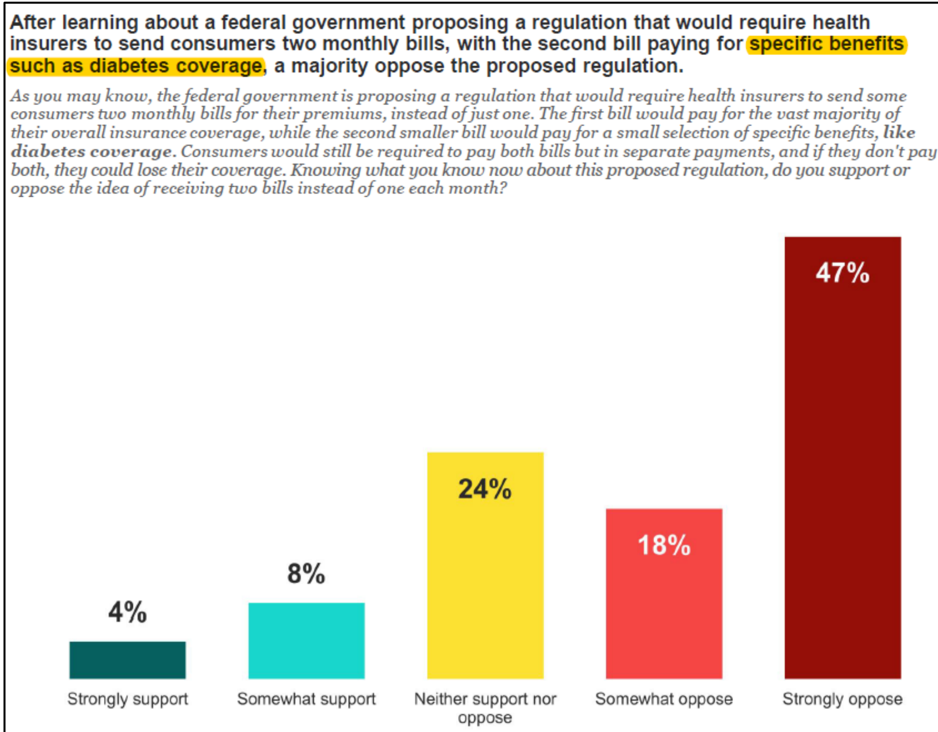
On behalf of AHIP, Morning Consult recently conducted a national survey to understand how consumers might react to and be impacted by the proposed requirement for separate billing and separate payment of premiums. Morning Consult conducted a survey of 1,044 registered voters who buy their own health insurance from December 13-26, 2018 (margin of error +/- 3 percent). Survey respondents represent a broad cross-section of Americans of various ages, gender, political affiliations, and religious beliefs.

Morning Consult summarized key survey questions and findings below:

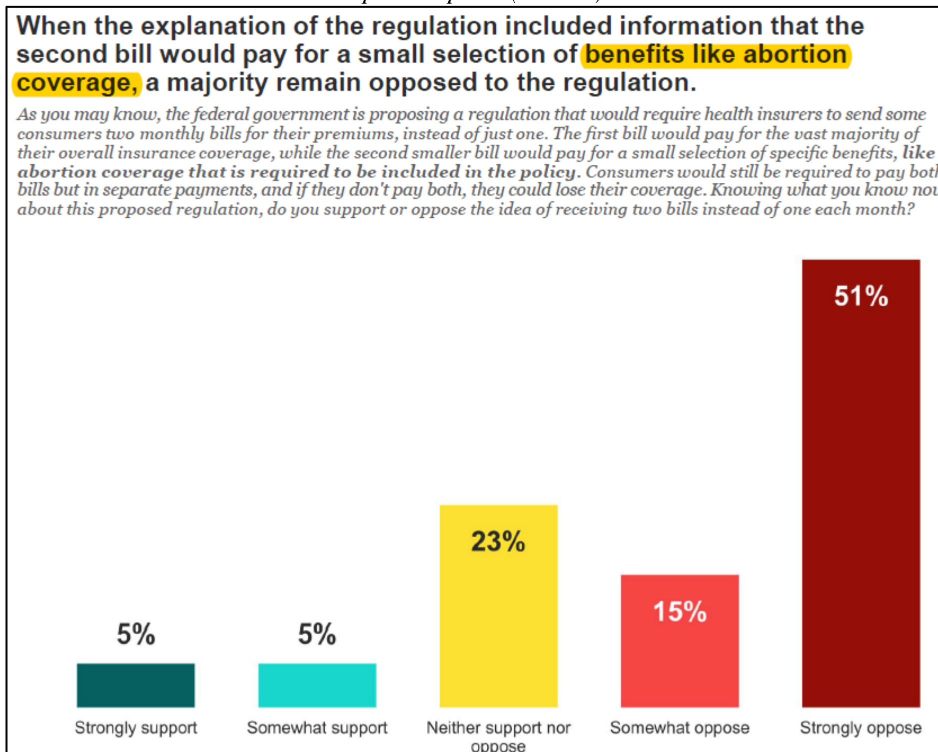



If the cost of health insurance premiums were to increase, a strong majority would be impacted.
If the cost of your yearly health insurance premiums were to increase, how much of an impact would the additional cost have on your and/or your family's ability to afford health care and other necessary expenses?
57%
31%
7%
3%
2%
Significant impact
Somewhat of an impact
Not a significant impact
No impact at all
Don't know/No opinion

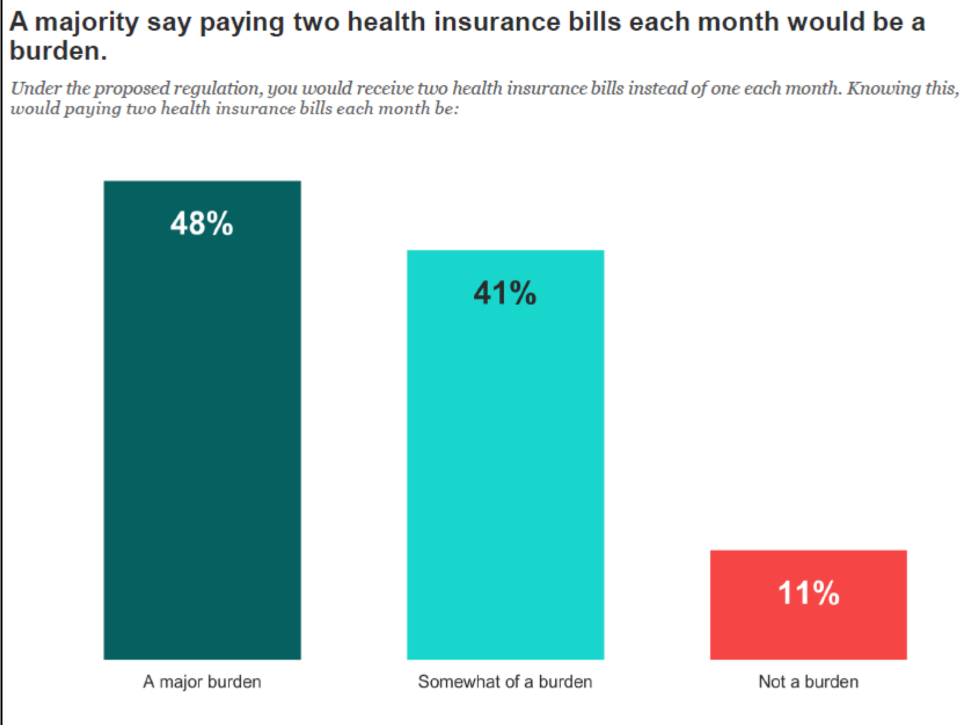

A strong majority (95%) think health insurers should make health care administration simpler. At the same time, a majority (55%) agree health insurers should make health care administration accommodate individuals, even if it raises cost for everyone.
And, thinking about your personal health care experiences, do you agree or disagree with the following statements?
Strongly agree
Somewhat agree
Somewhat disagree
Strongly disagree
Health insurers should make health care administration simpler, easier, and more efficient.
69%
26%

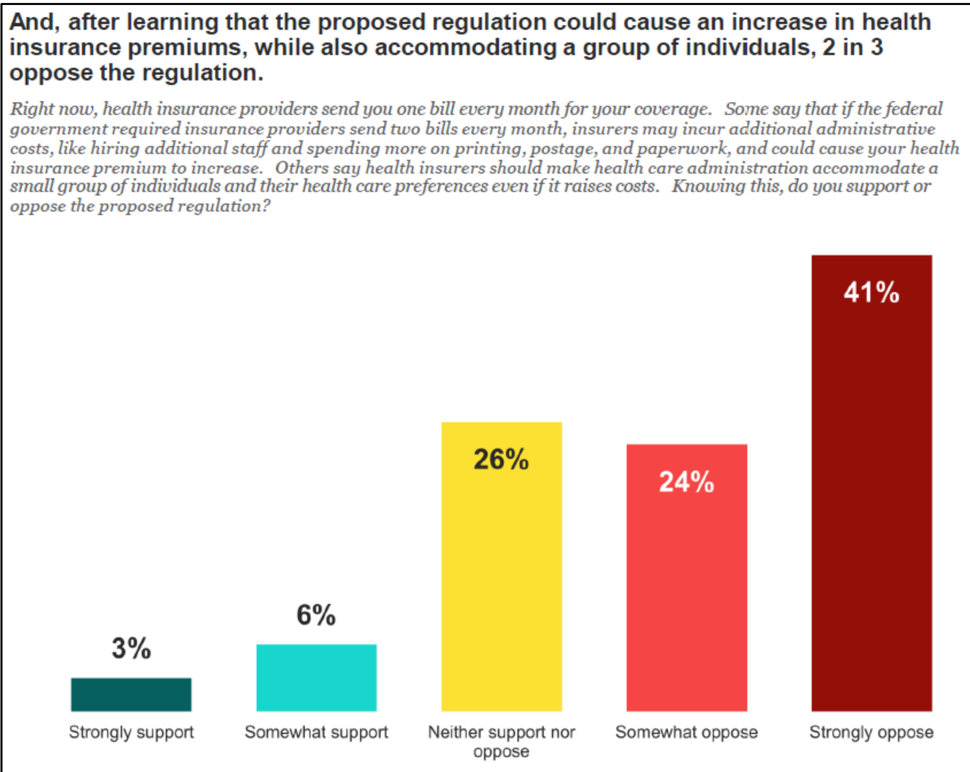


Split sample A (N=541)



Split sample B (N=503)


A majority say paying two health insurance bills each month would be a burden.
Under the proposed regulation, you would receive two health insurance bills instead of one each month. Knowing this, would paying two health insurance bills each month be:
48%
41%
11%
A major burden
Somewhat of a burden
Not a burden


And, after learning that the proposed regulation could cause an increase in health insurance premiums, while also accommodating a group of individuals, 2 in 3 oppose the regulation.
Right now, health insurance providers send you one bill every month for your coverage. Some say that if the federal government required insurance providers send two bills every month, insurers may incur additional administrative costs, like hiring additional staff and spending more on printing, postage, and paperwork, and could cause your health insurance premium to increase. Others say health insurers should make health care administration accommodate a small group of individuals and their health care preferences even if it raises costs. Knowing this, do you support or oppose the proposed regulation?
3%
6%
26%
24%
41%
Strongly support
Somewhat support
Neither support nor oppose
Somewhat oppose
Strongly oppose

Appendix B: Findings from AHIP Member Survey

A. Survey Overview

AHIP conducted a survey of member health insurance providers to estimate the potential costs QHP issuers would incur to comply with the proposed requirement for separate billing and collection of separate payments. We received 19 responses. Respondents included QHP issuers and vendors who conduct billing and payments for QHP issuer clients. Ten respondents currently provide coverage for non-Hyde services—whether voluntarily or due to a state mandate—and would be required to comply. These respondents were asked to estimate the potential administrative costs, operations burden, and time to implement. Nine respondents do not currently cover non-Hyde services, but provided input on the potential operations burden and time to implement if they were required to comply in the future (e.g., due to a new state mandate).

B. Cost and Implementation Estimates

Table 1: Issuer Estimates of One-Time Implementation Costs and Ongoing Annual Costs (N=9)[11]

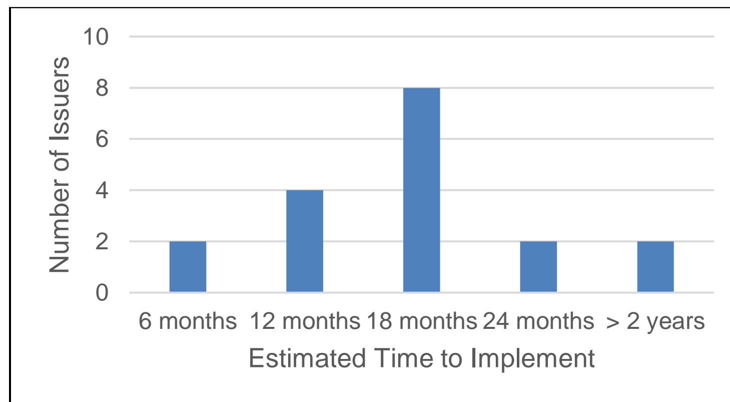
Respondent	Estimated One-Time Costs per QHP Issuer [12]	Estimated Annual Costs per QHP Issuer[13]
A	$50,000	$650,000
B	$90,000	$68,000
C	$100,000	$180,000
D	$330,000	$81,924
E	$500,000	$5,450,000
F	$1,500,000	Not provided
G	$3,125,000	$2,490,000
H	$5,000,000	$10,800,000
I	$7,500,000	$20 per additional bill

[11] One respondent who would be required to comply provided an estimate of covered lives but did not provide cost estimates.
[12] If issuer provided a range for implementation costs (e.g., $500,000 - $1 million), the estimated cost is the mid-point.
[13] If issuer provided a range for annual costs (e.g., $80,000 – $100,000), the estimated cost is the mid-point.

Table 2: Comparison of CMS Information Collection Burden Estimate and AHIP Administrative Cost Survey Responses (N=10)[14]

	CMS Information Collection Burden Estimate	AHIP Survey Respondent Estimates
Number Affected QHP Issuers	**75**	**10 respondents**
Number of Affected QHPs	**1,111** across all 50 states and DC	**756** across 9 respondents
Number of Impacted Consumers	**1.3 million** across all 50 states and DC	**2.4 million** across 10 respondents
One-Time Implementation Costs	**$841.60** per QHP issuer	**$50,000 to $7.5 million** per QHP issuer
Ongoing Annual Costs	**$1,452.22** per QHP	**$70,000 to $10.8 million** per QHP issuer

Table 3: Issuer Estimates of Time to Implement System Changes to Support Separate Billing and Collection of Separate Payments (N=18)[15]



C. Detailed Operations Burden and Cost Drivers

The 19 respondents to AHIP's survey identified operations processes they would have to newly implement or modify and costs they would incur to comply with the requirements for separate billing and collection of separate payments. These can be categorized as (1) one-time changes to support initial implementation; and (2) ongoing monthly processes and costs.

[14] One respondent who would be required to comply provided an estimate of covered lives but did not provide a number of QHPs or cost estimates.
[15] Eighteen respondents provided estimates of the amount of time it would take to implement changes to comply with separate billing and payments. This includes respondents would not immediately need to comply but provided an estimate if they were required to comply in the future (e.g., due to a new state mandate).

One-time changes an issuer would have to implement or change to comply with the requirements for separate billing and collection of separate payments:

- Changes to system architecture to allow multiple billing statements per policyholder
- Changes to enrollment system to identify enrollees subject to separate billing and payment requirements
- Changes to binder payment processing to collect two separate payments to effectuate enrollment
- Automate processes to generate separate invoices (mail or electronic communication)
- Automate processes to send separate invoice (mail or electronic communication)
- Changes to pay-by-phone and online payment portal to support dual invoices and separate payments, while also supporting combined payments for consumers who do not make separate payments
- Changes to call center training/scripting, response processes, billing-related outreach, and interactive voice response (IVR) technology
- Changes to processes to intake payments, including automating ability to match identify and match multiple payments from a policy holder
- Changes to process for enrollment and payment reconciliation, including 834 matching to effectuate enrollments
- Automate process to identify and notify enrollees who make a combined payment advising them they must make separate payments in the future
- Changes to enrollee notifications related to non-payment and the three-month grace period
- Automate processes for non-payment/terminations due to failure to pay premium due to separate payment requirement
- New processes to address scenarios where an enrollee's payment is not processed because the bank flags payment as potentially fraudulent (expected to occur for multiple payments in the same day or $1 payments)
- Update HICS/DOI complaint processes
- Changes to grievance/appeals processes
- Testing to ensure accuracy of separate billing processes

Ongoing monthly processes an issuer would have to support or costs the issuer would incur to comply with requirements for separate billing and collection of separate payments:

- Generate separate billing statements (paper or electronic) and additional member education materials to explain separate billing and payment requirement
- Quality assurance (QA) to ensure accuracy of separate billing statements
- Additional printing and separate postage for enrollees who receive paper invoices
- Electronic communications and payment links (e.g., to issuer's online payment portal) for enrollees who receive electronic invoices

- Fees for collecting and processing multiple payments, such as bank processing fees (issuers that currently allow credit card payments may stop offering this option as credit card processing fees would double)
- Additional customer service resources, including additional staffing and training, to address enrollee questions, confusion, frustration, etc.
- Increase resources for HICS/DOI case resolution
- Process and reconcile separate payments (paper and electronic) sent by enrollees
- Additional resources for manual review where automated processes are not able to reconcile enrollments and payments
- Identify and notify enrollees who did not send separate payments and send a notice that future payments should be sent separately (including postage and printing for paper notices)
- Identify enrollees who did not meet premium payment threshold and enter a grace period for non-payment of premium
- Additional costs to manage the grace period process for a higher volume of enrollees who enter a non-payment grace period (notices, termination, appeals process, reinstatement)