FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

January 8, 2019

The Honorable Alex Azar, Secretary
United States Department of Health and Human Services
The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

Re: 0938–AT53, file code CMS–9922–P

Comments on Proposed Rule involving Exchange Program Integrity

Submitted electronically via regulations.gov

Dear Secretary Azar and Administrator Verma:

Families USA, a leading national voice for health care consumers, is dedicated to achieving high-quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation – improvements that make a real difference in people's lives. In all our work, we strive to elevate the interests of children and families in public policy to ensure that their health and well-being is foremost on the minds of policymakers.

Families USA appreciates the opportunity to comment on the proposed rule addressing program integrity in health insurance exchanges. We address five separate features of the proposed rule: increased data-sharing to improve fraud detection and enforcement; moving consumers from unsubsidized exchange coverage to Medicare; preventing duplicative enrollment in coverage funded by premium tax credits (PTCs) and other publicly-funded programs; increasing federal authority over state-based exchanges' eligibility functions; and accounting rules that threaten women's access to reproductive health care.

Sharing Data to Detect and Combat Fraud Committed by Agents and Brokers

Families USA position: support.

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The proposed regulation would make clear that marketplaces can use personally identifiable information to investigate fraudulent practices of brokers, agents, and others. A marketplace could thus convey a consumer's personal information to an insurance regulator to assist in the latter's investigation.

Given the danger that fraud poses to consumers, this is a reasonable step. It may become even more important in the coming years, as enrollment pathways multiply outside exchanges; as new forms of health insurance unprotected by safeguards in the Patient Protection and Affordable Care Act (ACA) become available, such as short-term, limited duration insurance; and as agents and brokers receive financial incentives to steer consumers to forms of coverage that may not be in consumers' best interests.

Moving Consumers from Unsubsidized Exchange Coverage to Medicare

Families USA position: oppose in its current form. Replace automatic termination of exchange coverage with substantial outreach and consumer assistance directed at exchange enrollees who are about to qualify for Medicare.

One element of the proposed regulation involves consumers who are enrolled in qualified health plans (QHPs) without claiming PTCs. The rule would let such consumers authorize their exchange to do two things: (1) periodically "ping" HHS data to see whether the consumer has qualified for Medicare; and, if so, (2) terminate QHP coverage, providing the consumer with advance notice and an opportunity to revoke that termination.

This proposal addresses the situation of QHP enrollees who turn 65, qualify for Medicare, and begin receiving premium-free Medicare Part A coverage – potentially without realizing that such coverage has begun. Such consumers may unknowingly delay the start of Medicare Part B, subjecting themselves to higher premium costs when they later begin such coverage. These consumers may also pay more in QHP payments than they would pay for Medicare coverage. The rule gives consumers the option to authorize an automatic termination of exchange coverage when their Medicare eligibility begins.

This policy in its current form would create serious problems. Consumers who age into Medicare eligibility would automatically get only Medicare Part A and yet simply find their QHP coverage terminated, without being fully enrolled in other parts of Medicare. Coverage gaps could result, undermining seniors' access to care and financial security. If coverage gaps exceeded 63 days in length, they could also cause lifelong increases to Part D premiums after affected seniors sign up. Moreover, it is not completely clear that consumers would need to give fully voluntary and informed consent before this default arrangement was put in place.

A much better approach would have a QHP enrollee's imminent aging into Medicare automatically trigger both written notices and outreach from a navigator, the exchange call center, or another consumer assister who would help the QHP enrollee understand their options and make an informed

choice about how to proceed. With these complicated and confusing issues, one-on-one assistance can be essential to consumers receiving the kind of coverage they need and want.

The proposed rule identifies a real problem – the confusing transition from QHP coverage to Medicare, when a wrong choice can have serious and longstanding consequences. Unfortunately, the policy's current details threaten to do more harm than good. A far more robust strategy is needed to overcome this important challenge.

Data Matching to Prevent Duplicative Enrollment in PTC-Funded Coverage and Other Public Programs

Families USA position: oppose in its current form. Replace termination of PTC eligibility with substantial outreach and consumer assistance to help potential duplicate enrollees choose an appropriate course of action.

The proposed rule requires exchanges, twice a year, to match eligibility records of PTC beneficiaries with enrollment records for Medicaid, the Children's Health Insurance Program (CHIP), and Medicare. If data matches indicate that a PTC beneficiary is enrolled in one of these public programs, their PTC eligibility will be terminated, under the proposed rule.

In theory, regular matches of PTC records with information about other sources of coverage could be a positive step for consumers that also strengthens program integrity. Such matches could prevent some people from owing money when they file year-end federal income tax returns. Under the ACA, people are ineligible for PTCs if they qualify for forms of Medicaid or CHIP or receive forms of Medicare that the ACA classifies as "minimum essential coverage," or "MEC." In theory, measures like these could inform consumers when they are mistakenly receiving duplicative coverage, ending PTC-funded exchange coverage that otherwise could create year-end tax liabilities. More broadly, basing eligibility determination on data matches, rather than asking consumers to provide paper documentation, offers the potential to simultaneously accomplish three goals: (1) boosting eligible consumers' participation levels by eliminating red-tape barriers to enrollment; (2) increasing the efficiency of ongoing program operations; and (3) avoiding eligibility errors.

In practice, the proposed rule could pose a problem for consumers, rather than help them. In promulgating the regulation, HHS implicitly assumed the accuracy, comprehensiveness, and freshness of Medicaid eligibility records. In fact, state Medicaid agencies face serious challenges with their eligibility systems. In this case, not only must Medicaid programs provide near-real-time information about enrollment, the data must distinguish between forms of Medicaid that are MEC, and thus preclude PTC eligibility, and those that are not. It is essential that changes like those proposed by HHS not take place until after a careful advance analysis of Medicaid's data quality has been completed. Otherwise, PTC beneficiaries are likely to be erroneously terminated based on supposed Medicaid

MEC, ending eligible consumers' coverage rather than protecting consumers from year-end tax liability.

Moreover, even when reliable data shows duplicative enrollment, the proposed policy would have exchanges simply terminate PTC assistance and send a notice to the consumer. A much better approach is used by at least some state-based exchanges that conduct regular data-matching to identify duplication. Under this better approach, navigators or other assisters reach out to the consumer, explain the potential duplicative enrollment, see if in fact there is problematic duplication, and if so work with the consumer to facilitate a transition to the single source of coverage that is in the consumer's best interest. Such hands-on involvement is likely to be crucial to an effective eligibility transition for consumers who do not realize that they have two forms of coverage.

There is a broader problem with this part of the rule. Without any evidence of a serious problem in exchange eligibility determinations, the proposed regulation has the federal government micro-manage exchange operations by defining the frequency and nature of periodic data matches. Such federal regulations, which could potentially constrain exchange options to streamline enrollment, should not move forward without a clear showing that actual eligibility errors are significant.

Greater Federal Authority over State-Based Marketplaces

Families USA position: oppose.

The proposed rule requires state-based exchanges (SBEs) to provide additional information to HHS about eligibility and enrollment procedures and outcomes. It gives HHS an open-ended grant of federal authority to require each SBE to report to HHS about any virtually any topic, including eligibility verification procedures. The rule makes clear that HHS plans to use this information to mandate specific changes to policy and practice and potentially impose sanctions when an SBE does not comply with HHS requirements.

Along with this general expansion in federal authority, the proposed rule requires that annual exchange audits must sample eligibility outcomes to determine error rates. This is reminiscent of statutorily mandated federal Medicaid and CHIP eligibility reviews, which have deterred states from streamlining verification and enrollment procedures lest an unpredictable federal authority find fault with them after the fact.

The legal basis for this new assertion of federal authority appears questionable. Eligibility sampling, in the context of Medicaid and CHIP, resulted from very specific statutory direction to HHS. No remotely comparable statutory grant of authority applies to this new, regulatory assertion of federal power.

More broadly, HHS has not put forward evidence of SBE mistakes warranting this escalated level of federal involvement. The proposed rule's new and unwarranted requirements comprise a problematic extension of federal involvement in SBE operations, potentially preventing the kind of state

innovations that could increase enrollment of the eligible uninsured. This "solution in search of a problem" would likely undermine rather than improve exchanges' ability to achieve the ACA's core objectives.

Accounting Rules that would (1) Limit Women's Access to Reproductive Health Care and (2) Terminate Coverage Because of Consumer Confusion

Families USA position: oppose.

A particularly problematic part of this rule involves accounting for abortion services. The Hyde Amendment limits federal funding for abortions, and the ACA bars PTCs and cost-sharing reductions (CSRs) from being used to fund abortion services outside the scope allowed by the Hyde Amendment, a limitation on federally-funded Medicaid coverage that has long been contained in federal appropriations riders.

As part of the compromise around abortion that enabled the ACA's passage, the ACA authorizes plans to cover PTC beneficiaries' abortion services, so long as plans implement tracking procedures to ensure that consumer premium payments, rather than federal funds, cover the cost of non-Hyde abortions. Since the ACA's enactment in 2010, HHS has consistently given insurers three choices for meeting this accounting requirement in their interactions with members: (1) send each member a single bill each month that include distinct invoice items for non-Hyde abortion services and for other coverage, thereby allowing a single consumer payment to cover the entire bill; (2) provide consumers advance notice that their monthly bills will have a single charge, which will combine payment for non-Hyde abortion services with payment for other services, once again letting a single consumer payment cover the member's entire monthly bill; and (3) send each member two separate bills every month, one for non-Hyde abortion services and the other for everything else. Other regulations specify that plans must charge at least $1 a month for non-Hyde abortion services, even if such services raise premiums by less than a dollar or even reduce premiums.

The proposed rule would eliminate the first two options for plans to interact with their members. Instead, any plans that chose to cover non-Hyde abortion services would need to send separate bills, every month, for coverage of non-Hyde abortion services and for all other coverage. If bills are sent via "snail mail," two separate bills in two separate envelopes would go to the consumer, who would be asked to send in two payments in separate envelopes. Monthly electronic billing would also need to have two separate transactions for each consumer, a $1 charge for abortion services and another charge for everything else.

If a consumer mistakenly sent in a single payment covering both charges, the plan would have to accept that payment rather than terminate coverage. It would need to tell the consumer not to repeat the mistake, demanding separate monthly payments in the future. But if the consumer continued to make unitary monthly payments that covered the full combined cost of both monthly charges, the

carrier could not terminate coverage. In effect, carriers would be legally required to mislead their members by implying that failure to send separate payments would cause consequences that the carriers would be legally forbidden from imposing.

Mandating misleading messages is a sign of two deeper problems. First, if a confused consumer fails to send in their $1 payment for non-Hyde abortion coverage, the proposed rule requires the termination of the consumer's entire coverage, increasing the ranks of the uninsured by setting a trap for the unwary. This dramatic change in policy would terminate coverage based on confusion, despite consumers' attempts to "do the right thing" and pay their monthly bills. Second, rather than tackle the administrative challenges of dual monthly billing and accounting, as well as the obligation to mislead their members and the likely ill-will generated by coverage terminations for failure to make $1 payments, many if not most carriers are likely to simply stop offering non-Hyde abortion services. **The proposed rule thus converts the Hyde Amendment, an abortion restriction focused exclusively on federal funding, into a powerful tool for ending purely private coverage of abortion services.**

The Notice of Proposed Rulemaking seeks to justify this bizarre policy by claiming that, more than eight years after President Obama signed the ACA into law, the Trump administration now has a more accurate understanding than its predecessor about the ACA's goals and objectives. This argument lacks facial validity. Much case law holds that, when an agency changes a longstanding statutory interpretation, the earlier reading, closer in time to statutory enactment, is more likely to reflect contemporaneous legislative intent.

That rule applies even when a change in administration has not involved the kind of dramatic shift in policy position that is in play here. The Trump administration has repeatedly made clear its opposition to the ACA, to abortion, and, indeed, to women's broad access to birth control. This part of the proposed rule reflects the administration's policy preferences about women's access to reproductive health care, not a fair and reasonable interpretation of the ACA.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Stan Dorn or Cheryl Fish-Parcham at Families USA, 202-628-3030 or at sdorn@familiesusa.org and cparcham@familiesusa.org.

Respectfully submitted,

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