



Comments on Patient Protection and Affordable Care Act; Exchange Program Integrity

NY State of Health, New York's health plan Marketplace established pursuant to the Patient Protection and Affordable Care Act, submits the following comments on the Proposed Rule regarding 45 CFR Parts 155 and 156, Patient Protection and Affordable Care Act; Exchange Program Integrity [CMS-9922-P] (Proposed Rule). For the reasons stated below, the Centers for Medicare & Medicaid Services (CMS) should withdraw the proposed rule changes to section 156.280, Segregation of Funds for Abortion Services and modify the proposed changes to subparagraph (d) of section 155.1200, General Program Integrity and Oversight Requirements.

I. Segregation of Funds for Abortion Services (Sec 156.280)

As proposed, the changes to section 156.280 will have a harmful impact in the following ways:

Impacts on New Yorkers

- Consumer confusion
- Decrease access to care
- Increase cost-shifting of health care costs

Impacts on Health Care Providers

- Reverse recent reductions in uncompensated care

Impacts on the State

- Increase administrative burdens

Impacts on New Yorkers

Consumer confusion. While the preamble to the proposed rule argues that requiring separately issued bills will be less confusing than placing two bills in the same envelope (NPRM page 56023), we believe the opposite is true. This proposed rule imposes barriers that are not required under the ACA to purchasing qualified health plans. We anticipate that there would be significant consumer confusion resulting from the changes in this proposed rule. The receipt of two premium bills issued under separate cover – one for the share of premium attributable to non-Hyde abortion coverage and a second for the premium attributable to all other services – and the requirement to respond to those bills by sending two separate payments to health plans, will be very confusing and unduly burdensome to consumers.

We also expect that these proposed changes would likely result in termination of many consumers' coverage for non-payment due to the confusion surrounding dual premium monthly bills. Many consumers – men and women alike – could ignore this second (\$1) premium bill assuming it was sent erroneously and could lose critically important health coverage as a result.



Decrease access to care. The proposed rule will likely cause an increase in the number of uninsured New Yorkers and reverse important progress that has made health care more accessible in recent years. New York has seen a significant reduction in the rate of uninsured, from 10% in 2013 when the NY State of Health Marketplace opened to below 5% in 2017.

According to a recent Commonwealth Fund Survey:

- Nationally, in 2012 the share of individuals who reported they could not access needed care due to cost was 43%. This share dropped to 34% in 2016 nationally, and in New York the percentage dropped to 29% in 2016.
- Nationally, in 2012 the share of individuals who reported having trouble paying their medical bills was 41%. This share dropped to 37% in 2016, and in New York the number dropped to 28%.¹

Increase cost-shifting of health care costs. The proposed rule will reduce access to health care and increase the financial burden borne by the insured, the hospitals, and state and local governments. It is well documented that stripping individuals of their access to health care does not reduce their health care needs, and individuals without coverage still need and receive care. However, without primary and preventative care, and with no way to pay for care received, those costs are shifted to the insured, hospitals, and state and local governments.²

Impacts on Providers

Reverse recent reductions in uncompensated care. This policy will increase the number of uninsured New Yorkers, which in turn increases the fiscal and human costs of uncompensated care across the state. As noted above, since the implementation of the ACA, New York has drastically decreased the number of uninsured people in the State. New York hospitals have reported a dramatic decrease in self-pay hospital utilization because patients have gained insurance - a usual source of payment. New York State Institutional Cost Reports show a 23% reduction in self-pay hospital emergency room visits, a 40% reduction in self-pay inpatient services and a 17% reduction in self-pay outpatient visits. Having a usual source of payment for patients reduces the risk of uncompensated care costs.³ The proposed rule would endanger these usual sources of payment and the benefits that come with having a regular and reliable source of payment for healthcare costs.

¹ Declaration of Dr. Howard A. Zucker ISO Motion to Intervene of State of California, et al., (18-cv-167), April 6, 2018.

² Coughlin, Teresa A. "Uncompensated care for the uninsured in 2013: A detailed examination." (2014). <https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>

³ Declaration of Dr. Howard A. Zucker ISO Motion to Intervene of State of California, et al., (18-cv-167), April 6, 2018.



Impacts on the State

Cost of Countering Consumer Confusion. NY State of Health would face significant increased administrative costs associated with these proposed changes. These include increased call volumes to our Customer Service Center, required changes to consumer notices to provide information explaining this new requirement, translation of these notices into additional languages, information system costs to add information to the NY State of Health website and online application about this policy, and consumer education-related costs.

We anticipate increased call volumes resulting from consumer confusion over the receipt of two bills (including one for \$1), the requirement to remit two separate payments to their insurer, and most significantly from outraged consumers whose coverage has been terminated for non-payment of the second (\$1) premium bill. We estimate **Customer Service costs will increase by \$2.9 million per year** as a result of these increased call volumes.

There would also be a number of needed IT system changes, including production of a new consumer notice to all QHP enrollees; revising existing notices, in multiple languages, to ensure that consumers are aware of this change and the implications for loss of coverage if both premium bills are not paid; adding website banner messaging; adding help text to the online application for QHP eligible consumers to clarify plan billing; and testing to ensure that the information (application and notices) displays at the right time and to the right population. We estimate these **IT system costs would be between \$2.25 and \$2.75 million.**

Further, because NY State of Health consumer notices are system-generated, changes to the notices and website would require IT system coding changes and deployment. Given the proposed implementation timeline (immediately upon finalization) this would require that other priority system changes be delayed.

Finally, we estimate significant cost of consumer education to counter the expected confusion. This would include development of consumer education materials, advertising and outreach costs to ensure these materials reach their intended audience, and training of in-person assistors who work closely with consumers to enroll in marketplace coverage. We conservatively estimate these **outreach and education costs to be \$3.6 million per year.** This reflects one-quarter of NY State of Health's annual advertising and outreach budget, which is currently focused on promoting enrollment into marketplace coverage. The task of explaining these new rules would be significantly more challenging.

II. General Program Integrity and Oversight Requirements (Sec 155.1200)

Since its inception, NY State of Health has engaged an independent, external auditor to annually comply with the requirements of 155.1200. Based on this, we recommend that subparagraph (d)(2) remain unchanged, referring to part 155 generally as opposed to delineating particular subparts. The general reference to part 155 is consistent with HHS' stated intention to "specify or target the scope of a programmatic audit to address compliance with particular Exchange program areas or requirements." (NPRM, page 56021). This would allow HHS to specify those exchange functions that are most pertinent to a particular State Exchange model. (NPRM, page 56021).

Similarly, the proposed new subparagraph (d)(4) should be limited to clarify that compliance with eligibility and enrollment standards through testing to demonstrate accuracy is focused on QHP eligibility and enrollment, as follows:

*"Compliance with eligibility and enrollment standards through sampling, testing, or other equivalent auditing procedures that demonstrate the accuracy of eligibility and enrollment transactions **under subpart E of part 155.**"*

The independent, external audit focuses on part 155, which relates to exchange functions and processes. Individual determinations of eligibility for Insurance affordability programs such as Medicaid are covered in great detail elsewhere in statute (i.e. Title 42), and are currently subject to extensive audit requirements from multiple agencies. These functions should not be duplicated here.