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.