



August 22, 2013

The Honorable Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 310G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

On behalf of Virginia's physicians, hospitals and health systems the Medical Society of Virginia (MSV) and the Virginia Hospital & Healthcare Association (VHHA) respectfully ask that the Centers for Medicare & Medicaid Services (CMS) reconsider regulations governing Qualified Health Plans and Federally-facilitated Exchanges as they relate to the 90-day grace period for exchange plan enrollees that fail to pay their premiums (45 CFR Parts 155, 156, and 157).

Current Rules

Under the current rules established in recent final regulation, when certain individuals fail to pay their premiums to qualified Exchange health plans, they are permitted a 90-day grace period to bring their accounts up to date. The plan is required to pay all appropriate claims during the first 30 days of that grace period and may pend and eventually deny claims during the remaining 60 days of the grace period if coverage is ultimately terminated. When this happens, the health care provider becomes responsible for collecting payment from the patient or, if unsuccessful, going uncompensated for the care provided.

CMS initially proposed that health plans be required to pay all appropriate claims throughout the entire grace period, providing more certainty for the provider receiving payments and placing the plan at risk for paying claims in the absence of premium payments. This initial interpretation reflects the statutory requirement that plans "allow a 3-month grace period for nonpayment of premiums before discontinuing coverage" (P.L. 111-148, Section 1412 (c)). The revised, final interpretation allowing plans to deny appropriate claims for services provided during the last 60 days of the grace period represents discontinued coverage during that 90-day grace period. MSV and VHHA question whether this comports with the law. Moreover, the revised interpretation puts providers at risk for 60 days of unpaid claims that the patient is unlikely to pay. This creates a significant disincentive to providers to participate in exchange plan networks.

A Balanced Approach

CMS's changes as included in the final rule appear to conflict with the law and unduly place great risk on providers. If CMS insists this approach comports with the law, MSV and VHHA urge you to reconsider these regulations and develop a balanced solution that more equally distributes risk.

One alternative would be to reinsure patients against failure to pay their premiums. The cost of such reinsurance should be borne by all participants in the exchange and included in premium rates. Such an approach would openly acknowledge that some enrollees will not pay their premiums, better spread the financial risk of premium non-payment, and mitigate the administrative cost and hassle of pursuing reimbursement from patients who are unlikely to pay for the services rendered.

Appropriate Notification

An additional challenge with this provision is that CMS guidance to Exchange plans says they must "notify all potentially affected providers as soon as practicable when an enrollee enters the grace period." If providers are to be at risk for unpaid claims, insurers should be required to initially inform the potentially impacted providers within 15 days of the start of the grace period. Moreover, insurers should be required to provide real time responses regarding patient coverage status. If an insurer fails to provide accurate information regarding the patient's eligibility the insurer should be financially liable for the costs of unpaid services provided following the inaccurate eligibility statement.

A significant contributor to the challenges within today's American health care system is the pervasive uncertainty regarding what party bears financial responsibility for certain care and the expectation that providers absorb the brunt of unpaid claims. **We strongly urge CMS to seize this opportunity to prevent further exacerbation of this problem by reverting to the original proposed rule language regarding the 90-day grace period or more fairly distributing the risk of unpaid premiums and claims through the Health Benefits Exchanges.**

We would be pleased to discuss this issue with you in more detail if it would be helpful. Please contact Matt Mansell, MSV, at 804-377-1031 or Paul Speidell, VHHA, at 804-965-1221.

Sincerely,



Rufus C. Phillips, IV
Executive Vice President
Medical Society of Virginia



Laurens Sartoris
President
Virginia Hospital & Healthcare Association