Individual Premium Payment Management

Summary

The California Health Benefit Exchange has carefully considered three alternatives for handling payment of individual health care premiums to issuers. This briefing describes the alternatives, lists the advantages and disadvantages of each, and identifies a final recommended approach.

Background

The Exchange estimates that by the end of 2014, over 1.5 million Californians will have enrolled in a Qualified Health Plan (QHP) through the Exchange. By 2016 this number could grow to over 2.5 million individuals. All of these individuals will be responsible for paying all or a portion of their monthly premium costs.

The Affordable Care Act specifies that “a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan” (Section 1312, Consumer Choice). As a result, the California Exchange cannot require its individual members to remit premium payments to the Exchange. Estimates of the number of members who will choose to remit payments directly to their Qualified Health Plan issuers are not currently available. The Exchange could provide members with the option to remit premium payments directly to the Exchange. Any payment processing and aggregation services the Exchange offers would therefore apply only to a subset of Exchange members.

According to an August 2011 U.S. Department of Treasury informational directive, the Treasury will make direct deposits to insurance companies of federal subsidies such as Advance Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR). The directive specifies that the advanced payment will be reconciled against the amount of the family’s actual premium tax credit, as calculated on the family’s federal income tax return.

Whatever approach is selected will need to be fully in place by October 1, 2013. Depending on the approach chosen, the systems and operational support could include functionality to:

- Calculate premium payments
- Issue premium payment notices to members
- Manage electronic and paper check member premium payments
- Collect dishonored premium payments [*]

The approach the Exchange selects regarding how issuers receive premium payments will have a significant impact on Exchange members, Qualified Health Plan issuers, and Exchange

[*] Based on the California Department of Motor Vehicles’ dishonored payment volumes for FY 2010/11, the Exchange estimates that over 3% of payments will be dishonored, requiring substantial resources to trace and process these transactions.

operations. Accordingly, the Exchange has analyzed the following three alternative approaches described below in the options chart:

1. Exchange Manages Collection and Aggregation
2. Vendor Manages Collection and Aggregation
3. Direct Payment Approach

Under federal regulations the Exchange also has the option of accepting directly from Indian Tribes, Tribal organizations, or urban Indian organizations, aggregated plan premiums on behalf of qualified individuals. This brief does not address this option. A recommendation regarding this option will be developed in consultation with California's Tribes.

Recommended Approach

Staff recommend that the Board choose the Direct Payment Approach (Option 3). The Direct Payment option is less costly, simpler to administer, avoids losses related to dishonored payments, and avoids the potential confusion of Exchange enrollees regarding where payments are to be made for their coverage. Premium aggregation would involve creating and operating two procedures to manage premium payments and to assume financial responsibility for dishonored payments. The administrative difficulties inherent in the other approaches are likely to cause very high per member per month costs. Direct payment to the issuers eliminates this complexity while complying with federal mandates.

Not offering enrollees the option to make payments through the Exchange could impact the extent to which the Exchange's subscribers see the Exchange as an important source for economical and/or subsidized health coverage. On one-hand, the Exchange could lose some of the brand-identity that comes from the reinforcing of the Exchange by having the regular billing communications with consumers. At the same time, the Exchange could be seen more negatively as the entity that "cancels coverage" for non-payment and deals with payment disputes.

As part of this recommendation, the Exchange would adopt policies and requirements in its agreements with Qualified Health Plans that would assure the Exchange that it has access to Qualified Health Plan subscribers, describe the form and nature of how bills to subscribers, require plans to provide billing information that reinforces the role of the Exchange, clearly identify the amount of the subsidy provided through the Exchange to pay for the subscriber's coverage, and use the Plan's regular billing communication with subscribers to provide information on behalf of the Exchange. This additional information could be provided by taking advantage of unformatted message space on the billing statement or through inserts in the bill statement envelope. The Exchange would retain the responsibility for initiating contact with subscribers regarding open enrollment activities each year and Qualified Health Plans would be required to coordinate with the Exchange on communications to subscribers. The role of the Exchange would also be reinforced by billing and other communications providing information on how the Exchange can serve as an effective point of contact to provide direct customer

service to help resolve billing or other issues that a subscriber may have with the plan's services.

Individual Premium Payment Management
Options Chart

Option 1	Option 2	Option 3
Exchange Manages Collection and Aggregation	**Vendor Manages Collection and Aggregation**	**Direct Payment Approach**
SUMMARY The Exchange would elect to manage the collection of individual premium payments from the subset of members who choose to remit payments to the Exchange, aggregate the collected payments, and forward them to QHP issuers. The Exchange will thus absorb, and must offset, the cost of premium payment administration for this subset of Exchange members.	**SUMMARY** The Exchange would elect to contract out the management of individual premium payment processing and aggregation for the subset of members who opt to remit payments to the Exchange.	**SUMMARY** The Exchange would leverage the QHP issuers' existing payment processing infrastructure and direct Exchange members to remit premium payments directly to their QHP issuer. . Premium billing would be developed to clearly identify both the Exchange and Health plan on the bill and the federal tax credit that is reducing the premium obligation to the consumer. The Exchange would also provide consumer assistance for unresolved billing questions and other issues.
PROS ▪ Reduces the cost to QHP issuers of premium payment administration; this may be a benefit to issuers in the Exchange although the cost to the Exchange which is ultimately charged to the health Plans would likely provide a net increase in costs. ▪ Provides the Exchange with more control over premium payments for the subset of members who opt to remit payments to the Exchange ▪ Provides the subset of Exchange members who opt to remit payments to the Exchange with a single point of contact for eligibility, enrollment, and premium payment status and problem resolution ▪ Allows the Exchange to offset its administrative costs for the subset of members who opt to remit payments to the Exchange by subtracting them from the premiums collected rather than by invoicing QHP issuers	**PROS** ▪ Offers the same advantages as Alternative 1 ▪ Provides greater flexibility in establishing the infrastructure and operations required to process premium payments for this subset of Exchange members	PROS ▪ Fully meets the ACA's requirement that members be allowed to remit payment directly to QHP issuers ▪ Relies on QHP issuers for premium payment processing to Exchange; issuers already have the requisite payment processing infrastructure and administrative overhead accounting procedures in place ▪ Accords with Treasury policy related to the distribution and reconciliation of APTC and CSR. ▪ Eliminates the complexity associated with accommodating two premium payment remittance processes ▪ Lowest cost solution.

<table>
<tr><th>Option 1</th><th>Option 2</th><th>Option 3</th></tr>
<tr><th>Exchange Manages Collection and Aggregation</th><th>Vendor Manages Collection and Aggregation</th><th>Direct Payment Approach</th></tr>
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<td>CONS
▪ Requires the Exchange to implement two sets of processes for tracking and reconciling premium payments, one for payments remitted directly to the Exchange, and a second for those remitted to QHP issuers
▪ Requires building a State payment processing infrastructure from the ground up in fewer than 18 months, including building this functionality into the Exchange IT system, establishing relationships with the State Controller and Treasurer, and hiring and training State staff
▪ Because the number of members who will opt to remit payments to the Exchange is unknown, processing volume is unknown; scaling the staff to support this function will be difficult
▪ Requires the Exchange to assume the cost of processing dishonored payments while building a financially sustainable operation by January 2015
▪ May require a State clearing account for dishonored payment instruments and funding to cover ongoing losses
▪ Likely to increase the total cost of health coverage as Health Plans costs for premium processing is likely less than the costs that would be incurred for a lower volume of payments processed by the Exchange.</td>
<td>CONS
▪ Possesses the same disadvantages as Alternative 1, except for the requirements associated with standing up a State operation
▪ Requires a comprehensive and transparent procurement process, including development of a Request for Proposal, competitive bid evaluation, and potential bidder protests; estimated time to complete – six months
▪ Requires the selected vendor to stand up a complete payment processing infrastructure in less than one year, including the implementation of an IT system and hiring and training staff
▪ Outsourced vendors likely are a higher cost, given that the Exchange would be processing lower volumes than existing plan payment processing operations.</td>
<td>CONS
▪ Requires Exchange members to remit payments to an entity other than the Exchange; the role of the Exchange in members' access to health coverage would be focused primarily on eligibility and enrollment processes, outreach and marketing, service center and support/referral services
▪ Requires the Exchange to invoice QHP issuers to collect charges assessed to support the Exchange operating costs</td>
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