



August 15, 2013

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

Dear Administrator Tavenner:

On behalf of physicians and hospitals across the state of Wisconsin, the Wisconsin Medical Society and the Wisconsin Hospital Association respectfully ask the Centers for Medicare & Medicaid Services (CMS) to reconsider a worrisome provision in the recent regulations governing Qualified Health Plans and Federally-facilitated Exchanges (45 CFR Parts 155, 156, and 157). Our specific concern relates to the grace period allowance for exchange plan enrollees. If this provision is not corrected, we fear that hospitals and physicians in Wisconsin (and indeed across the country) will decline to participate in qualified exchange health plans.

The current rules require qualified exchange health plans to grant certain individuals a 90-day grace period during which their coverage cannot be terminated for failure to pay premiums. The plans are required to pay all claims during the first 30 days of that grace period, but are allowed to pend and deny any claims during the remaining 60 days if the coverage is ultimately terminated. This process unduly burdens physicians, hospitals and other health care providers with a double whammy: First, they provide the care. Then, they bear the burden of having to collect private payment from the patient for care rendered during the final 60 days of the grace period if the patient fails to pay his/her premium, or shoulder the unfair and significant risk for providing uncompensated care. This dual burden simply is not fair.

Recognizing that pended claims in the extended clemency would place a heavy burden of uncertainty on the provider community; CMS initially proposed that health plans be required to pay all appropriate claims during the entire grace period. And we fully supported that provision. But the final rules were amended, leaving the providers without adequate protection. The rules do require the plans to notify providers when patients have entered the grace period, but that notification only has to be made "as soon as practicable," an undefined standard that is subject to wide interpretation by the health plans. At a minimum, a more specific and timely reporting mechanism must be mandated.

We also are very concerned that some disreputable individuals will learn they can manipulate the system and win a full year's insurance coverage on only nine months of premiums. Knowing they are entitled to three months of grace period coverage, dishonest persons could stop paying premiums on the ninth month, enjoy free coverage during the 90-day grace period, have their coverage terminated,

and then re-enter the exchange market where the Affordable Care Act's guaranteed issue mandate would prohibit another plan from denying them coverage. While we prefer to think this sort of scheming would be rare, we are not convinced this won't become a significant problem, especially for the health care providers.

Thus, we ask CMS to restore the original provision and require the plans to pay claims during the entire grace period. While that restoration is being promulgated, we strongly urge you to make the notification process accessible whenever a provider needs to inquire, and to make it consistent with the current real-time standards for electronic HIPAA verification transactions (X12N 270/271), which generally require health plans to transmit eligibility information within 20 seconds.

Physicians, hospitals and other health care providers cannot reasonably be expected to know or predict if an enrollee's premiums are paid or will be paid before the end of the grace period. And they cannot reasonably be expected to bear the concomitant burden of uncertainty and a potentially significant financial loss. If the current rules cannot be amended or interpreted in a more equitable manner, we fear there will be a widespread reluctance among physicians and other providers to participate in exchange plans. As a result, many patients — especially those in under-served areas — will find it very difficult to find physicians and other providers willing and able to provide their care.

Thank you for the opportunity to comment, and thank you for your consideration.

Sincerely,



William R. Abrams
Chief Executive Officer
Wisconsin Medical Society



Stephen F. Brenton
President/CEO
Wisconsin Hospital Association