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Congress of the United States
House of Representatives
December 20, 2013

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The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

On December 11, 2013 you testified before the House Energy and Commerce Subcommittee on Health regarding the current status of implementation of the Affordable Care Act (ACA). During this hearing, both Congressman Barton and I raised concerns about the ability of patients who enrolled through Healthcare.gov to access care in the first few months of 2014. On December 20, 2013 POLITICO also reported the absence of a streamlined data transfer process from Healthcare.gov may result in erroneous enrollments and failed payments after January 1, 2014. In those circumstances where care is provided, under the assumption that coverage does in fact exist, a serious liquidity issue is raised and I am concerned about who will carry the financial burden at the end of the day if the systems do not work fully as intended.

Since the launch of HealthCare.gov on October 1, the website has been plagued by a series of technical glitches and errors. While some of the basic front-end problems individuals have experienced on the website since the initial launch on October 1 have been addressed, questions remain about the back-end functionality of the system that will actually transmit an individual's enrollment information to an insurer. The success of this transfer ultimately can impact the patient's ability to access a provider.

Changes the Administration supposedly designed to make it easier for consumers to buy insurance through the health insurance exchanges only further raise concerns for the physicians, providers and hospitals that will ultimately provide the care. In a press call on December 4, 2013, Julie Bataille, the Center for Medicare and Medicaid (CMS) spokesperson, told reporters that there is no mechanism by which the Advanced Premium Tax Credit (APTC) determined by CMS will be transmitted to the insurer.

As it was envisioned, the Federally Facilitated Marketplace (FFM) would transmit accurate consumer information and would facilitate payment from the Treasury for consumers who qualify for an APTC to insurers, who then would transfer the information and reimbursement per the plan contract, to the providers who provide the service to the patient. Physicians, hospitals, and other health care providers rely on insurance reimbursements to continue operating their practices. While consumers may enroll in a plan and pay their premium by December 23, it is unclear whether the government will hold up its end of the agreement and ensure the enrollment information and payment makes it all the way to the provider. To date I am unaware of testing to ensure an APTC will follow a consumer properly and make it to the insurance plan.

There have been numerous press reports recently about issues with the transfer of the EDI 834 Benefit Enrollment and Maintenance documents (commonly referred to as 834s). I am concerned that several situations may arise after January 1, 2014 that could pose barriers to care delivery and serious payment issues including:

- 1) A patient goes to a provider and receives care, the provider contacts the insurer the patient states they enrolled with through Healthcare.gov, but the insurer has no record of the patient's enrollment as the 834 was never transmitted from Healthcare.gov, although CMS does have a record of their application;
- 2) A patient receives care from a provider, the provider contacts the insurer the patient states they enrolled with through Healthcare.gov and while the insurer has a record of the patient's enrollment, the insurer never received the APTC from the Treasury for the patient;
- 3) A patient receives care from a provider, the provider contacts the insurer the patient states they enrolled with through Healthcare.gov and while the insurer has a record of the patient's enrollment a premium payment was not received from the patient;
- 4) A patient receives care from a provider, the provider contacts the insurer the patient states they enrolled with through Healthcare.gov and while the insurer has a record of the patient's enrollment, the cost-sharing subsidy was miscalculated resulting in either an overpayment or shortfall for the provider;
- 5) A patient receives care from a provider, the provider contacts the insurer the patient states they enrolled with through Healthcare.gov but neither the insurer nor CMS have a record of the patient's application or enrollment

As you are aware, the Administration has taken action to delay or modify provisions of the Affordable Care Act, often after the deadlines by which insurers were expected to comply with the new requirement of the law. Most recently, on December 12, just one day after you assured Members of the Energy and Commerce Committee that you did not know of future delay, the Department of Health and Human Services (HHS) proposed loosening the coverage rules further, urging insurers to cover individuals retroactively who may have not paid by the January 1 deadline. While I understand the intention of this announcement is to address some of these complications and potential disruption in the care and reimbursement of patient care, I fear the increasing number of delays may further complicate, not address, the core problems of the law.

America's Health Insurance Plans (AHIP) President and CEO Karen Ignagni highlighted the effect the continued changes to the original Affordable Care Act's framework have had on the insurance plans, stating the delays may "exacerbate challenges associated with helping consumers through the enrollment process." The White House announced last Wednesday, December 13, that a little more than 365,000 Americans have "selected" plans in both state and federal exchanges—which doesn't necessarily mean they have paid the first premium. Out of those claims HHS reported that over 15,000 applications that were completed never made it to insurance companies.

The faulty enrollment mechanism in the Federally Facilitated Marketplace (FFM) could lead to even more Americans to go without healthcare coverage. Not only do individuals face barriers to enroll in an insurance plan through the failed technology within Healthcare.gov, but those who have enrolled in a plan and paid their premium prior to the deadline may also be left without access to necessary healthcare if the back-end infrastructure of the FFM is not operational on January 1.

In order to understand the status of ACA implementation and how applicant's information and payments will flow through the system, please provide the following information:

1. Describe the processes and procedures that will be in place, if any, for providers to contact the Department of Health and Human Services in the case that a patient attests to being enrolled in an Exchange plan, but the insurer has no record of their enrollment.
2. Describe the processes and procedures that will be in place, if any, to verify whether an individual's provider that is now out-of-network as of January 1, 2014 will be billed as in-network for the first fifteen days of January 2014.
3. Describe the processes and procedures that will be in place, if any, to recoup any monies from cost-sharing subsidies that were incorrectly calculated.

4. In the case that a payment is not transmitted from an insurer to the provider or from the FFM to the insurer, who will be responsible for making the provider or insurer whole?
5. Has HHS considered contingency plans for a failure of properly calculated APTCs, those APTCs that fail to follow the consumer, or the failure of the transmission of the APTC?
6. Describe the processes and procedures that will be in place, if any, to address "bad debt" that hospitals or providers may incur due to a delay in payment from the Exchange plans because of a failure of the transfer of an 834 or incorrect data.
7. Please clarify whether in the situation that an enrollee seeks care from a provider with whom they had a relationship with prior to January 1, there is anything in the statute or regulation that guarantees that provider will be treated as in-network. Please describe the processes or contingency plans you have in place, if any, to ensure continuity of care for patients, especially for those individuals who may be in the middle of treatment for a serious condition or in the midst of a series of surgical procedures.
8. Describe how potential costs associated with provider payments for individuals whose providers are no longer covered as encouraged by the guidance issued by HHS on December 12, 2013 would be handled.
9. Describe the processes and procedures that will be place, if any, to address the calculation of the "Medical-Loss Ratio" as set forth in the Affordable Care Act, in consideration of the additional regulations and changes through "administrative discretion" that have been promulgated by the Administration since the initial enactment of the law. Insurers that have had to take on additional administrative costs to establish workarounds, and some of the other "manual" activities as a result of the early implementation issues should be able to adjust their administrative expenses in the 2013 MLR reporting. Please specifically address the costs associated with the 834 issues, the insurer reconciliation of previous inaccurate transmissions with correct transmissions.
10. Describe the processes and procedures that will be in place, if any, for HHS to work with the States to reconcile the Medicaid enrollment data that has already been transmitted since October 1, 2013.
11. Describe the processes and procedures that will be in place, if any, to process maintenance of record requests from individuals for "Life Qualifying Events", such as the birth of a child, divorce, or the addition of a spouse.

Thank you for your prompt attention to this matter. While it is the end of the year, given the timely issues at hand I hope you can work with me to provide this information as soon as possible. If you have further questions regarding this request please contact myself or J.P. Paluskiewicz or Sarah Johnson with my staff in my Washington, D.C. office at James.Paluskiewicz@mail.house.gov or Sarah.Johnson@mail.house.gov .

Sincerely,

A handwritten signature in blue ink, appearing to read "M. Burgess", with a stylized flourish at the end.

Michael C. Burgess, M.D.
Member of Congress