Health Benefit Exchange Authority

Proposed Rule on Financial Sustainability

Assessment of Health Carriers

Comment Letters (in order of receipt)

Comment Deadline: March 31, 2014

Created April 1, 2014

Index

Principal Financial Group

Government Relations

March 27, 2014

VIA ELECTRONIC MAIL (mary.senkewicz@dc.gov)

Mary Beth Senkewicz
Associate General Counsel & Policy Advisor
DC Health Benefits Exchange
1100 15th Street, NW, 8th Floor
Washington, DC 20005

RE: Proposed Rulemaking to Title 26, Subtitle D, Health Benefit Exchange, Health Carrier Assessments

Dear Ms. Senkewicz:

On behalf of Principal Life Insurance Company ("Principal"), I am writing to comment on the DC Health Benefit Exchange Authority's Proposed Assessment Rule for Financial Sustainability. We appreciate the opportunity to provide input on the proposed funding mechanism to ensure the sustainability of the District of Columbia Health Benefits Exchange, DC Health Link.

Principal offers life, annuity, disability income, as well as dental, vision and critical insurance products in all 50 states and the District of Columbia. The proposed draft at issue addresses Exchange assessments and, as written, the proposed policy would apply to all carriers "doing business in the District."

Principal has several serious concerns with this proposed funding methodology and believes that an open-ended assessment or tax, as proposed, is not the solution for an efficient, sustainable, fiscally prudent Exchange, nor does it promote "reasonable projections." This tax, which would be assessed beginning in June 2014, is for an unspecificed amount that will be determined by the Authority on an annual basis. Notably, the proposed rule would assess all health carriers, including those offering coverage for disability income and critical illness and other types of HIPAA excepted benefits coverage that are not permitted to be sold on the DC Health Link. We urge you to reconsider this proposed rule.

Any assessment on health insurers should be limited to insurance products that have a direct relationship to the Exchange.

As noted, the proposed rule would assess all health carriers, resulting in assessments on all types of health insurance, including those offered by Principal which are disability income (group and individual), dental and vision insurance, as well as critical illness coverage. These benefits are considered HIPAA excepted benefits. These important coverage options are designed to serve as financial protection for consumers, and are recognized under the ACA and by Congress as products that are entirely separate from major medical coverage.

Disability income and critical illness, for example, are federally prohibited from being sold on the Exchange and derive no direct or indirect benefit from the Exchange. Further, some of these policies are "non-cancellable," which ameans premiums cannot be increased over the life of the policy to adjust for additional, unexpected assessments. This factor alone makes this type of coverage very different from a one year-renewable term medical policy. A driving force behind the ACA is to provide more people financial protection from an unfortunate health event. Loss of income during a health event is a problem for consumers as well, and many of them are not covered by disability insurance. As the insurance industry continues to work to come up with ways to make disability income and critical illness policies

more affordable for a greater portion of the population, subjecting unrelated insurance products to an Exchange assessment will increase premiums on consumers.

Federal agencies have acknowledged the intent to exclude HIPAA excepted benefit products from ACA insurance and market reforms. Majority of states that developed Exchanges exclude HIPAA excepted benefits from their funding mechanism. We encourage the Authority to recognize that by requiring an assessment on HIPAA excepted benefits, would unnecessarily compromise the viability and affordability of policies that are relied upon by families to provide financial protection. Therefore, we ask you to consider only those plans actually participating in the Exchange be made subject to assessments and fees.

Further, the proposed Assessment would require that all dental carriers, whether or not the dental carrier is a Qualified Dental Plan ("QDP"), and regardless of their participation in DC Health Link, be subject to the annual assessment to fund the DC Health Link. Clearly, plan participation in DC Health Link provides for certain benefits not available to nor realized by plans participating outside of DC Health Link.

Also, it is important to note that the dental insurance industry is very different than the medical insurance industry. Simply put, dental does not have the same profit margins as medical. Medical maintains a much larger profit margin base. After taxes, Principal's dental profits are less than 3%. As a result, assessments of this nature result in increased premiums on the consumer. Applying a blanket assessment equally across all plan participants, without consideration for industry or profit margin, is a very inequitable and non-consumer friendly position. We propose the Exchange has the flexibility to provide varying fee schedules to its Exchange plan participants.

We certainly understand the Board's heavy task at hand with respect to funding the Exchange. However, we urge you to recognize that carriers participating on the Exchange will have the advantage of built-in marketing/advertising that will likely increase their overall enrollment. Therefore, it is only appropriate that the carriers who will ultimately receive the direct benefits of the Exchange, then pay for the Exchange.

However, should the Board insist assessments be made against all carriers regardless of Exchange participation, we request any assessments on non-participating carriers be significantly less than those carriers who choose to participate on the Exchange. Simply applying a blanket assessment equally across all health carriers, without consideration of Exchange participation, is a very inequitable and non-consumer friendly position. We propose the Board has the flexibility to provide varying assessments to those carriers on and off the Exchange.

We trust the Exchange Board will take these comments into consideration. Thank you again for the opportunity to provide you with our perspective on these important issues.

Sincerely,

Catherine Drexler

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Principal Financial Group

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SIIA
SELF-INSURANCE INSTITUTE OF AMERICA, INC.

PROTECTING AND PROMOTING SELF-INSURANCE AND ALTERNATIVE RISK TRANSFER SINCE 1981

March 27, 2014

Mila Kofman, JD
Executive Director
DC Health Benefit Exchange Authority
1100 15th Street, NW, Eighth Floor
Washington, D.C. 2000S

RE: Proposed Health Carrier Assessment Regulations

Dear Director Kofman:

The Self Insurance Institute of America (5IIA) is a national trade association that represents companies involved in the self-insurance marketplace, including self-insured organizations and their business partners. Our organization has members based in Washington, D.C. or who provide products and services to self-insured employers in the District.

We have concerns about scope of the assessments proposed in this regulation, specifically whether the Health Benefit Exchange intends to assess stop-loss insurance carriers. Our view is that it should not and that the final regulations should clarify this matter accordingly.

The regulation notes the statutory basis for the assessment "Pursuant to § 31-3171.03 of the Act, the Authority is authorized, through rulemaking, to charge user fees, licensing fees, or other assessments on health carriers..." After reviewing the relevant section of law, DC Code appears to explicitly exclude stop-loss coverage from subsection (C):

> (e) (1) The Authority is authorized to charge, through rulemaking:
> (A) User fees;
> (B) Licensing fees; and
> (C) Other assessments on health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges.

As you know, stop-loss insurance is neither sold on or off the health exchange, nor a considered to be a qualified health plan under D.C. Code § 31-3171.01(12) so assessing such carriers would be contrary to the existing statutory framework.

Thank you for your attention to this important matter. Should you have any questions or would like to discuss in more detail, please contact SIIA State Government Relations Director Adam Brackemyre at 202/463-8161, or via e-mail at abrackemyre@siia.org.

Sincerely,

Michael W. Ferguson
President & CEO

KAISER PERMANENTE

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

March 28, 2014

Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street, NW, 8th Floor
Washington, DC 20005

Re: District of Columbia Health Benefit Exchange Authority's Assessment Rule Informal Comment Discussion Draft

Dear Ms. Senkewicz:

Thank you for the opportunity to comment on the proposed new Subtitle D (Health Benefit Exchange) of Title 26 (Insurance, Securities, and Banking) of the District of Columbia Municipal Regulations.

The proposed regulations would allow the DC Health Benefit Exchange Authority (the "Authority") to annually assess each health carrier doing business in the District an amount based on a percentage of its direct gross receipts as necessary to support the operations of the Authority.

The proposed regulations indicate that all carriers that have $50,000 or more in District of Columbia-based gross receipts per year would be subject to the assessment. It is our understanding that major medical, Medicare Supplement, and other HIPAA-excepted benefit products would be included in the calculation. The gross-receipts of Medicaid managed care organizations (MCOs) would also be included.

Kaiser Permanente supports the intent of the Authority to implement a broad-based funding mechanism to support the operations of DC Health Link. By including the gross receipts of all types of health benefit products in the assessment methodology, the assessment will be less of a financial burden on any one entity. Conversely, to require that only those carriers participating in DC Health Link pay the assessment would impose a significant burden on only a few carriers, essentially penalizing those carriers for offering plans through DC Health Link. Assessing only the carriers participating in DC Health Link is likely to lead to increased premiums and cost sharing and/or reduced benefits for plans purchased through DC Health Link in future years, undermining the goals of DC Health Link and the Affordable Care Act.

Furthermore, the carriers offering products through DC Health Link in 2014 will not necessarily be those participating in DC Health Link in future years. In order to have a well-functioning Exchange that encourages carriers to offer products in future years, we believe it is reasonable

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and appropriate to require all insurers of health risks in the District of Columbia to pay a portion of the total assessment amount.

Kaiser Permanente requests that the funding base for DC Health Link operations be expanded to include as broad a base as possible. All insured persons and entities in the District of Columbia will benefit from the effects of near-universal coverage—stabilizing the risk pool, reducing health care costs and eliminating uncompensated care losses—intended by the Affordable Care Act and implemented through a combination of the Medicaid expansion and the availability of affordable insurance through DC Health Link. Assessing a smaller portion of the total assessment amount to a broader set of entities will ensure sustainable funding for DC Health Link while preventing year-to-year instability in premiums for plans sold through DC Health Link.

As you are aware, Kaiser Permanente actively participated in the Authority's Financial Sustainability Working Group. During those meetings, Kaiser Permanente and other commercial plans argued for a broader funding mechanism that included other organizations in addition to carriers that would benefit from the availability of affordable coverage for District residents. We request that the Authority reconvene the Financial Sustainability Working Group in 2015 to identify additional funding sources for DC Health Link, including DC general fund revenues.

Thank you for your time and consideration. Please feel free to contact me at Laurie.Kuiper@KP.org or 301.816.6480, if you have any questions or require additional information.

Sincerely,

Laurie G. Kuiper
Senior Director, Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc

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Julia M. Huggins
President, Mid-Atlantic Region

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March 28, 2014

VIA ELECTRONIC MAIL

Ms. Mary Beth Senkewicz
Associate General Counsel and Policy Advisor
DC Health Benefits Exchange
1100 15th Street NW
Washington, DC 20005

Dear Ms. Senkewicz:

I am writing to express Cigna's serious concerns about the proposed new rules establishing a subtitle D (Health Benefit Exchange) of Title 26 (Insurance Securities and Banking) of the District of Columbia Municipal Regulations entitled "Health Carrier Assessments."

Cigna is dedicated to helping the people we serve improve their health, well being and financial security. Cigna offers products and services under the Connecticut General Life Insurance Company (CGLIC) or the Cigna Health and Life Insurance Company (CHLIC). These Cigna companies proudly serve our District of Columbia (District) customers by providing health care solutions to meet their unique needs.

Cigna finds a number of the provisions within these proposed rules to be highly questionable. Cigna finds particularly troubling what appears to be an attempt by the Exchange Authority (Authority) to levy a "gross receipts" tax on non-exchange insurance products. The language in the proposed rule is extremely vague regarding how far the reach of this proposed "gross receipts" tax would extend. It is our understanding that the Authority intends to levy this assessment on a wide variety of insurance plans including those that offer coverage for disability income, long term care, fixed indemnity and other types of health benefits. Please provide in response to these comments an exhaustive list and detailed description of all the "gross receipts" and types of insurance policies or benefit plans that are intended to be taxed under this rule proposal.

Moreover, Cigna is concerned that the Authority lacks the statutory power to tax or levy assessments on any insurance product that is not sold on the District of Columbia Exchange. Section (e)(1) of the District of Columbia official code Section 31-3171.03 limits the Authority via its rulemaking power as follows:

> "The [Exchange] Authority is authorized to charge, through rulemaking:
> (A) User fees;
> (B) Licensing fees; and
> (C) Other assessments on health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges."

In light of the plain language of this city ordinance, where does the Authority believe its statutory power to levy any assessment of a non-Exchange based insurance policy or any "gross receipts" tax resides? In response to these comments, please provide a detailed legal opinion that answers this question.

Cigna is also concerned about the open ended manner in which the amount of the assessment is to be determined by the Authority on an annual basis. We understand that this amount is to be determined annually based on what the Authority expects to spend in a given year. Such a process could be subject to significant variations year over year.

Dramatic swings of tax rates could create difficulties for Cigna customers to annually budget their expenses. These additional taxes and the uncertainty of this process could create a negative business climate for our customers. Small employers in particular need to meticulously budget every last dollar in order to retain employees, create jobs and reinvest in their products or services.

Cigna is also a member of America's Health Insurance Plans and joins in the comments that they may submit on this rule proposal.

Cigna believes that these proposed rules are ill-defined and urges the Authority to defer their adoption. Cigna's employer customers need certainty and clarity in order to manage their expenses and properly budget their health plan costs, unfortunately these proposed rules provide neither.

Thank you for the opportunity to express these concerns.

Sincerely,

Julia M. Huggins

Julia M. Huggins
President,
Cigna Mid-Atlantic Region

America's Health Insurance Plans

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March 28, 2014

Mary Beth Senkewicz, Associate General Counsel & Policy Advisor
DC Health Benefits Exchange
1100 15th Street, NW, 8th Floor
Washington, DC 20005

Re: Proposed Rulemaking, Title 26, Subtitle D, Health Benefit Exchange, Health Carrier Assessments

Dear Ms. Senkewicz,

On behalf of America's Health Insurance Plans (AHIP), I am writing to comment on the proposed rulemaking that would establish a new Subtitle D (Health Benefit Exchange) of Title 26 (Insurance, Securities, and Banking) of the District of Columbia Municipal Regulations, titled "Health Carrier Assessments." This proposed rule, published on February 28, 2014, establishes a funding methodology to ensure the sustainability of the District of Columbia's health benefits Exchange, DC Health Link. AHIP is the national trade association representing the health insurance industry. Our members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual and small group insurance markets, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and have also demonstrated a strong commitment to participation in public programs.

This new Subtitle would allow the DC Health Benefits Exchange Authority (Authority) to assess, on an annual basis, each health carrier doing business in the District with direct gross receipts of $50,000 or greater in the preceding calendar year. Further, the new Subtitle indicates that the Authority shall adjust the assessment rate on an annual basis, with the caveat that the amount assessed shall not exceed reasonable projections regarding the amount necessary to support the operations of the Authority.

AHIP has several concerns with this proposed funding methodology and believes that an open-ended assessment or tax, as proposed, is not the solution for an efficient, sustainable, fiscally prudent Exchange, nor does it promote "reasonable projections." This tax, which would be assessed beginning in June 2014, is for an unspecified amount that will be determined by the Authority on an annual basis. Notably, the proposed rule would assess <u>all</u> health carriers, including those offering coverage for disability income, long-term care, fixed indemnity and other types of HIPAA excepted benefits coverage that are not permitted to be sold on DC Health Link. We urge the Authority to reconsider this proposed rule, as funding the DC Health Link by only taxing those licensed as health carriers in the District does not reflect the public benefit that the Exchange offers to the entire District .

We also recommend further open discussion to review other funding opportunities that may not have been wholly investigated during the initial financial sustainability discussions held in early 2013. We believe that basing the entire funding mechanism on carriers only, both those serving the DC Health Link and those with little or no relationship to the Exchange, ignores other alternative, more appropriate funding sources within the District, or available to the District, that would better serve District residents, the Exchange, and the health insurance market.

The Authority needs a budget that is fair, balanced, and sustainable for the future.
Consideration of how to fund the DC Health Link requires a transparent and open discussion about Exchange operations and administration. The proposed June implementation of this funding plan means that insurers have not incorporated this additional assessment into premiums for this year, nor will they be able to do so for 2015. Without having the time to appropriately and accurately predict and include such assessments in premiums, this proposal risks creating significant price increases in the future. Any discussion of funding must take into account the question of affordability and feasibility for all populations and entities served by the DC Health Link. As proposed, this funding mechanism has the potential to negatively impact premiums across a wide range of health insurance products, notably including those insurance products not offered on the Exchange.

An open-ended funding mechanism is not a fiscally prudent, balanced, or sustainable methodology.
Before determining how to fund the DC Health Link, there should first be the benefit of an actual operating budget from the Authority, and justification of future projections. The proposed rule states that the amount to be assessed will be adjusted each year, based on projections of the amount necessary to support the operations of the Authority. For the following reasons, we strongly object to an open-ended assessment amount that is established without an open and transparent process and can be implemented without justification:

- An amount that varies each year is difficult to administer and creates unstable fluctuations in premiums from year to year. This translates into variable and potentially costly implications for consumers and could negatively impact the intent of the DC Health Link - to provide affordable coverage options.
- The projected budget for the Authority will need to be set very early in the previous year in order to allow for carriers to file rates that reflect the next year's assessments. If the assessment amount varies from year to year, any delay in the Authority's budget could have serious implications and repercussions for both carriers and consumers.
- An open-ended assessment lacks sufficient incentives for the Authority to appropriately manage resources and meet specific budget targets. The Authority should be held to the same standards as other public entities - an open and transparent budget that is scrutinized and evaluated by external audits and review processes. At present, the Authority can authorize any assessment amount and health insurance carriers could face unprecedented regulatory assessments that could reverberate into higher, unstable premiums and a need to reevaluate market participation.

A broad funding base that equitably reflects the value of DC Health Link coverage to the community should be considered.
We share the Authority's goal of adopting a sustainable funding mechanism that achieves affordability for consumers and meets the operating costs of the DC Health Link. We believe that this requires a more robust consideration of existing and new funding sources across a base that reflects that the DC Health Link benefits not only the entire DC community, but also benefits federal programs that are using the DC Health Link. In making a final decision on funding for the DC Exchange, the Authority should thoroughly explore whether existing funding sources and cost allocations are appropriately assigned to reflect the new role of the DC Health Link in operating an interface for eligibility and enrollment support and integration for other government funded programs, including Medicaid, CHIP, and the Federal coverage for members of Congress and their staff.

Other ideas for funding, based on a broader base of entities that directly benefit from the expanded number of insured enrollees in the Exchange, should also be considered, such as health care providers, manufacturers of pharmaceuticals and medical device makers and suppliers. Further, a portion of current taxes on products that contribute to increasing health care costs (e.g., alcohol and tobacco taxes) would reflect the recognition of the costs those products impose on health and could be redirected to help fund Exchange operations. Such an approach would ultimately mean lower premiums for consumers buying coverage through the Exchange and underscore the public health benefit that the DC Health Link offers to the District.

Funding methods should have a direct relationship to the Exchange or the purpose of the Exchange.
As noted, the proposed rule would assess all health carriers, resulting in assessments on all types of health insurance, including disability income, long-term care, fixed indemnity, and other types of HIPAA excepted benefits coverage. These important coverage options are designed to serve as financial protection for consumers, and are recognized under the ACA and by Congress as products that are entirely separate from major medical coverage.

These products are federally prohibited from being sold on the Exchange and derive no direct or indirect benefit from the Exchange. Further, some of these policies are "non-cancellable," which means premiums cannot be increased over the life of the policy to adjust for additional, unexpected assessments. Subjecting these unrelated insurance products to an assessment will increase premiums in those products that have the ability to make policy changes on an annual basis and disrupt the coverage that thousands of individuals, families, and small businesses in the District rely on for financial protection.

Federal agencies have acknowledged the intent to exclude HIPAA excepted benefit products from ACA insurance and market reforms and most states that have developed Exchanges exclude HIPAA excepted benefit products from the funding mechanism. AHIP believes that it is inappropriate to include premiums for HIPAA excepted benefit products not offered through DC Health Link in any funding mechanism. Including HIPAA excepted benefit products in any

funding tax not only unfairly targets these products but may also have unintended, negative consequences for the consumers who choose to purchase them.

DC Health Link enrollees should not subsidize federal programs.
Any budget proposal must fairly reflect the DC Health Link's additional administrative functions assumed in lieu of the Office of Personnel Management (OPM). As of early February 2014, nearly 50 percent of DC Health Link enrollees are congressional employees[1], yet the proposed funding rule does not seek specific funding from OPM to account for the administrative functions involved in enrolling these congressional employees. Congressional employees are likely to remain a significant portion of the enrollees in the DC Health Link. It is not appropriate for an Exchange to include administrative costs for services performed for other governmental programs or agencies, particularly if funding is to come from only one segment of the stakeholders who benefit from the coverage provided by an Exchange.

Given that the decision regarding the inclusion of congressional employees in DC's Health Link was not determined until after the Financial Sustainability Working Group concluded their work last April, AHIP recommends that the Authority develop a method to ensure the Exchange is reimbursed with federal funds that were previously allocated to OPM. Beginning in 2014, premiums for congressional employees who have enrolled in the Exchange include the two percent tax on health insurance premiums in the District, just as premiums do for other enrollees. It is a reasonable expectation that these "new" premium tax dollars could also be redirected to the Exchange, as a reflection of the significant role the Exchange plays in the administrative functions it is now performing for these congressional employees. This redirection of "new" premium tax monies is not without precedent, as both Washington State and New York have implemented similar policies of using existing state revenue streams to help fund their state-based Exchanges.

Opportunities may exist to recapture attributed Medicaid administrative costs.
In addition to the cost for congressional employees, the costs incurred by the DC Health Link for individuals who are enrolled in Medicaid should also be examined to determine what administrative costs should be attributed to the Medicaid program.

We understand that it is the Authority's intention to include Medicaid Managed Care Organizations (MCOs) in the assessment base. AHIP believes that it is inappropriate to include in the assessment base the premiums of products not offered through DC Health Link, including Medicaid MCOs. Further, federal law requires state Medicaid agencies to reimburse MCOs for the value of the assessment[2]. The American Academy of Actuaries has determined that actuarially sound rates for Medicaid MCOs are to include "any state-mandated assessments and

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[1] *"More Than 12,000 Congressional Staffers Have Enrolled in Health Plans Through Obamacare."* Washington Post Article February 20, 2014

[2] Section 1903(m)(2)(A)(iii) of the Social Security Act mandates that MCO rates must be determined on an "actuarially sound basis," and federal regulations under Section 42 CFR §438.6(c)(1)(i)(A) require that rates be "developed in accordance with generally accepted actuarial principles and practices."

taxes."[3] Therefore, if the DC Health Benefits Exchange chooses to apply the assessment to Medicaid MCOs, we request that the Department of Human Services be directed to incorporate the assessment amount that will be levied into their budget, in order to include it in the capitation payments to MCOs.

Transparency of assessment.
AHIP would once again request that any entity being taxed as part of a funding mechanism for the DC Health Link be allowed to clearly indicate to consumers what portion of their premium is attributable to the assessment. This type of transparency will allow consumers to understand that a portion of their premium is being used to fund the DC Health Link's operation and reflects the need for a transparent budget and operation of the Exchange.

Rather than seeking to spend the remaining federal grant funding before the end of 2014, the Authority should explore opportunities to extend the use of allocated funds into 2015.
Several states have made requests to CMS that they be able to use existing Exchange §1311 federal Exchange development grant monies into 2015. More recently, CMS has commented that it will allow, with no penalty, the extension of federal grant monies into 2015 within certain parameters. Given that this opportunity was not included in any previous financial sustainability discussion, we strongly recommend that the Authority investigate the possibility of using federal monies beyond the December 31, 2014, expiration date of the federal planning and establishment grants. Not only will this allow the Authority to make efficient and effective use of these monies, it will also allow the additional time necessary to develop a sustainable, forward-thinking funding mechanism that will benefit DC residents, the DC Health Link, and the District, while incorporating funding alternatives that were not previously known as options.

Further analysis is needed on the Authority's legal basis to expand an Exchange assessment beyond carriers that market QHPs and QDPs.
A careful examination of the legislation authorizing the establishment of DC Health Link calls into question whether the Authority has a sustainable legal basis to assess carriers that are marketing products other than QHPs or QDPs. The authorizing legislation establishing the Exchange Authority also provides the Exchange Authority an explicit funding mechanism outlined at D.C. Official Code § 31-3171.03(e)(1):

> (e) (1) The [Exchange] Authority is authorized to charge, through rulemaking:
> (A) User fees;
> (B) Licensing fees; and
> (C) Other assessments on health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges.

The unambiguous text in § 31-3171.03(e)(1) indicates that any "user fees," "licensing fees" and "other assessments," may be imposed only on "health carriers selling qualified dental plans or

[3] American Academy of Actuaries, Health Practice Council Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs, August 2005.

qualified health plans in the District." The phrase "health carriers selling qualified dental plans or qualified health plans" clarifies which entities may be assessed, while the phrase "*other* assessments" explicitly links both "user fees" and "licensing fees" to that subset of carriers "selling qualified dental plans or qualified health plans." In further support of this legal argument, this assessment is not a "user fee" because those not selling products on the DC Health Link are not users of the Exchange, and it is not a "licensing fee" because the DC Health Link is not an issuer of licenses or a regulatory body.

As indicated herein, AHIP has significant concerns with the proposed rule that seeks to fund the DC Health Link. We share the Authority's goal for a successful, financially sustainable health insurance market and stand ready to work with you to find a solution that will ensure a robust marketplace. We appreciate your time and consideration of our comments and recommendations and look forward to additional deliberations on this important issue. If you have any questions or would like additional clarification of these comments, please feel free to contact me directly. I can be reached by telephone (202-778-1149) or by email (gtrujillo@ahip.org).

Sincerely,

gtrujillo

Geralyn Trujillo, MPP
Regional Director

cc: Kevin Wrege

D★C★I★F
District of Columbia
Insurance Federation

Ms. Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street, NW 8th Floor
Washington, DC 20005

28 March 2014

Dear Ms. Senkewicz,

Thank-you for the opportunity to comment on the proposed Rulemaking to establish a new Subtitle D (Health Benefit Exchange) under Title 26 (Insurance, Securities and Banking), and, in particular, a new Chapter 1, titled "Health Carrier Assessments."

I write in opposition to this proposal for the following reasons:

- It is unfair to assess companies generating premiums from products not permitted to be sold on the Exchange. In short, this is "Assessment without Representation"!
- It is unfair to expect a small collection of companies, generating a relatively small premium base through the sale of products permitted to be sold on the Exchange, to bear the overwhelming burden of sustaining the Exchange.

With a population of approximately 600,000 residents, the District of Columbia presents a limited market for the Health Insurance segment. Similarly narrow markets – for example, Vermont – have addressed the sustainability of its Exchange with a hybrid approach: funding comes from a mix of select industry assessments, plus a contribution allocated from the general fund. Other jurisdictions have approached sustainability in a variety of ways. No other jurisdiction has implemented an approach similar to the one proposed for the District of Columbia.

The DC Insurance Federation applauds the work accomplished thus far to create an Exchange that promises to well serve its prospective constituents. We pledge our support toward developing a sustainability formula that is fair, equitable and in keeping with our understanding of the federal guidelines.

Yours very truly,

Ross Hess, RPLU+
President

cc: Councilmember Yvette Alexander
Interim Insurance Commissioner Chester A. McPherson, Esq.
RTFB Administrator Wayne E. McOwen, ARM, PLC

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District of Columbia
Insurance Regulatory Trust Fund Bureau

P.O. Box 78160 * Washington, DC 20013

28 March 2014

Ms. Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street, NW 8th Floor
Washington, DC 20005

Dear Ms. Senkewicz,

Thank-you for the opportunity to comment on the proposed Rulemaking to establish a new Subtitle D (Health Benefit Exchange) under Title 26 (Insurance, Securities and Banking), and, in particular, a new Chapter 1, titled "Health Carrier Assessments."

I write in opposition to this proposal for the following reasons:

- It is unfair to assess companies generating premiums from products not permitted to be sold on the Exchange. In short, this is "Assessment without Representation"!
- It is unfair to expect a small collection of companies, generating a relatively small premium base through the sale of products permitted to be sold on the Exchange, to bear the overwhelming burden of sustaining the Exchange.

With a population of approximately 600,000 residents, the District of Columbia presents a limited market for the Health Insurance segment. Similarly narrow markets – for example, Vermont – have addressed the sustainability of its Exchange with a hybrid approach: funding comes from a mix of select industry assessments, plus a contribution allocated from the general fund. Other jurisdictions have approached sustainability in a variety of ways. No other jurisdiction has implemented an approach similar to the one proposed for the District of Columbia.

The DC Insurance Regulatory Trust Fund Bureau applauds the work accomplished thus far to create an Exchange that promises to well serve its prospective constituents. We pledge our support toward developing a sustainability formula that is fair, equitable and in keeping with our understanding of the federal guidelines.

Yours very truly,

Lawrence Anthony Richardson
Chairman of the Board of Directors

cc: Councilmember Yvette Alexander
Interim Insurance Commissioner Chester A. McPherson, Esq.
RTFB Administrator Wayne E. McOwen, ARM, PLC

UnitedHealthcare

800 King Farm Blvd., Suite 600
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March 28, 2014

Ms. Mary Beth Senkewicz
Associate General Counsel and Policy Advisor
Health Benefit Exchange Authority
1100 15th Street, N.W.
8th Floor
Washington, DC 20005

Dear Ms. Senkewicz:

UnitedHealthcare is pleased to provide the District of Columbia Health Benefit Exchange Authority with our comments regarding the Health Carrier Assessments Proposed Rule released on February 28, 2014.

Consistent with our previous remarks on Exchange financing, in the long term, we believe that the cost to operate the DC Health Benefit Exchange should be borne by the qualified individuals, employers or Qualified Health Plans inside the Exchange and not solely by Carriers operating in the District. While we strongly urge the Authority to adopt a user-based fee as its long-term Exchange financing mechanism, in the short term we understand that there will not be adequate membership to take this approach and as such, the need for a broad-based Carrier assessment. We suggest that the proposed regulation be modified to authorize the broad-based assessment to a period of two years, at which time Exchange financing would be re-evaluated to determine if, based on the costs to operate the Exchange and the total membership, a user-based fee is feasible. We also recommend that the final rule impose a ceiling on the maximum assessment rate so as to ensure the Authority's operations costs remain reasonable. Further, all funds collected should include a transparent plan as to how the funds will be allocated to specified Exchange activities. Any unspent funds from a prior year should carry over to the allocation of funds for the next fiscal year for the Exchange and should not revert to the DC Government for general fund or other non-Exchange usage.

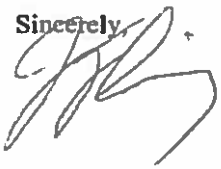
Regarding assessment calculation, while we are pleased that the Authority is proposing to extend the timeframe to pay the assessment to 30 business days, we continue to recommend that any assessments be defined as a per member per month amount rather than based on percentage of gross receipts for the preceding calendar year. Doing so will be more reflective of Carriers' current business volumes and result in a more equitable assessment across Carriers.

Additionally, any fees or assessments used to finance the Exchange should be considered a state tax or assessment as outlined in the Affordable Care Act and its implementing regulations, and

should be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates, to the full extent allowed by federal regulation.

Thank you again for the opportunity to provide feedback. Please feel free to contact me if you have any questions.

Sincerely,



John E. Fleig, Jr.
Chief Operating Officer
UnitedHealthcare Mid-Atlantic Health Plan

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TRANSAMERICA®

100 Light Street, Floor B1
Baltimore, MD 21202-2559

March 31, 2014

Ms. Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street NW, Eighth Floor,
Washington, D.C. 20005

Re: Comments regarding the DC Health Benefit Exchange
Proposed Health Carrier Assessment

Dear Ms. Senkewicz:

On behalf Of Transamerica Direct, I appreciate the opportunity to submit comments to the DC Health Benefit Exchange Authority (Authority) on the proposed rulemaking that would implement the Health Carrier Assessment. It is our view that that the proposed rule does not comply with applicable District of Columbia statutes and Patient Protection and Affordable Care Act guidance regarding health insurance exchanges. We request that the proposal be withdrawn.

This proposed rule, published on February 28, 2014, establishes a funding methodology to ensure the sustainability of the District of Columbia's health benefits Exchange, DC Health Link. The proposal allows the Authority to assess, on an annual basis, each health carrier doing business in the District with direct gross receipts of $50,000 or greater in the preceding calendar year. Under the proposal, the Authority shall adjust the assessment rate on an annual basis, with the caveat that the amount assessed shall not exceed reasonable projections regarding the amount necessary to support the operations of the Authority.

In its current form, this proposed funding methodology is an open-ended assessment which does not provide health carriers with a "reasonable projection" and does not provide stability for the Exchange. The proposed rule bases the entire funding mechanism on carriers only, both those serving the DC Health Link and those with little or no relationship to the Exchange, ignores other alternative, more appropriate funding sources within the District, or available to the District, that would better serve District residents, the Exchange, and the health insurance market.

We recommend further open discussion to review other funding opportunities that may not have been wholly investigated during the initial financial sustainability discussions held early last year. We join our trade associations and other carriers in sharing your objective of a financially sustainable health insurance market and we are ready to assist you in identifying a more appropriate solution. We appreciate your consideration of our comments on this important issue.

Sincerely,

Edward Walker
President, Transamerica Direct

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COMBINED INSURANCE®

March 31, 2014

Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street, NW, 8th Floor
Washington, DC 20005

Re: Proposed Amendment to Title 26 of the DC Municipal Regulations, Subtitle D, Health Benefit Exchange, new Chapters 1 and 99, concerning assessment upon "health carriers".

Dear Ms. Senkewicz:

Combined Insurance Company of America writes only "excepted benefit" and life insurance products in the District of Columbia. Combined is a member of both the American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP). We agree with the legal and public policy comments they have filed and also oppose these proposed rules. Thank you for the opportunity to comment on the Authority's proposed assessment rules.

Sincerely,

Reynold E. Becker
Government Relations Director
847-953-8131
reynold.becker@combined.com

L. Noel Patterson, Jr.
Regional Counsel
Law and Regulation

March 31, 2014

Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street NW, Eighth Floor
Washington, DC 20005

(sent via electronic mail to mary.senkewicz@dc.gov)

re: Notice of Proposed Rulemaking—Health Benefit Exchange Authority

Dear Ms. Senkewicz:

Allstate welcomes the opportunity to comment on the proposed Rules. Initially, and to be clear, the comments on the proposed Rules are not intended to be nor should in any way be construed as a criticism of the DC Health Benefit Exchange or the Affordable Care Act. That said, it is respectfully submitted that the proposed funding mechanism for the Exchange exceeds the scope of the Exchange's Rule making authority and works a fundamental, and possibly illegal, unfairness upon providers of HIPAA excepted benefits who currently choose to operate in the District.

The Executive Board of the District of Columbia Health Benefit Exchange Authority ("The Board") may only promulgate Rules under authority specifically and expressly provided by the Council of the District of Columbia. The specific and express Rule making authority is contained in DC Code § 31-3171.01,*et seq.* The Rule making authority granted in this statute gives the Board the ability to, by rule, charge user fees, licensing fees and other assessments on health carriers "selling qualified dental plans or qualified health plans"[1].

Allstate offers insurance products that are HIPAA excepted, are not major medical health insurance and are not obligated, when payable, to reimburse any of the costs of health care. Examples of these products include long term care benefits, disability benefits, and accident coverage. Like most HIPAA excepted products, these products have a health event trigger, but are payable to the insured, not to any health provider. These products are most often considered financial protection tools. They are <u>not</u> qualified health plans and, it therefore follows, assessment upon the carriers issuing these products exceeds any Rule making authority of the Board.

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[1] [§31-3171.03—emphasis added](e) (1) The Authority is authorized to charge, through rulemaking:

(A) User fees;

(B) Licensing fees; and

(C) ***Other assessments on health carriers selling qualified dental plans or qualified health plans in the District***, including qualified health plans and qualified dental plans sold outside the exchanges.

Allstate Insurance Company
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Furthermore, in accordance with the provisions of the Affordable Care Act, these products cannot be sold on the Exchange. It is fundamentally unfair for an insurance carrier that does not (and indeed by federal statute cannot) participate in the Exchange to have to pay an assessment to fund the Exchange.

It is respectfully reiterated that the assessments authorized by the District of Columbia are unequivocally limited to health carriers selling qualified health plans in the District. The proposed Rule seeks to assess health carriers with a threshold amount of direct gross receipts "on all health insurance risks originating in or from the District of Columbia[2]". This phrase appears to be carefully engineered to capture carriers currently offering non- qualified, HIPAA excepted benefits into the assessments used to fund the Exchange. As stated above, this is beyond the scope of any Rule making authority and furthermore is fundamentally unfair. The Board is urged to reconsider its proposed Rule and limit any assessment of health carriers to those carriers who participate in the Exchange.

Sincerely,

L. Noel Patterson, Jr.

[2] Proposed Rule 100.1 seeks an annual assessment on each "health carrier doing business in the District with direct gross receipts of $50,000 or greater...". Proposed Rule 9900.1 defines direct gross receipts as "all policy and membership fees and net premium receipts or consideration received in a calendar year **on all health insurance risks originating in or from the District of Columbia.**" (emphasis added)

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Edward J. Donahue, Jr.
Second Vice President
Regional Director and Counsel

March 31, 2014

Mary Beth Senkewicz, Esq.
Associate General Counsel and Policy Advisor
DC Health Benefit Exchange Authority
1100 15th St NW; 8th Floor
Washington, DC 20005

RE: OPPOSITION to Proposed Subtitle D, Chapter 1. Health Carrier Assessments addition to Title 26: Insurance, Securities and Banking of the District of Columbia Municipal Regulations. – Health Benefit Exchange Authority Funding Assessment

Dear Ms. Senkewicz:

Aflac, the nation's leading provider of supplemental health insurance products, appreciates the opportunity to submit these comments in opposition to the DC Health Benefit Exchange (the "Exchange") proposal to assess insurance premiums derived from "all health insurance risks originating in or from the District of Columbia". This proposal was adopted by the Health Benefit Exchange Authority Executive Board on February 12, 2014 and submitted for approbation of the District Council effective March 4, 2014.

The proposal would establish an assessment on health insurance premiums pursuant to a formula based on "direct gross receipts" of insurers which would be derived from "all health insurance risks originating in or from the District." This formula would deliberately assess health insurance products ineligible to be sold on the Exchange as well as major medical insurance. This approach is unique in the country and raises many legal, practical and fairness questions for insurers, consumers and regulators. We maintain it is unfair to carriers and policyholders to assess products which cannot be written in the Exchange to pay the expenses of the Exchange.

Aflac sells supplemental health insurance products not health benefit plans or major medical coverage. Our policies pay money to help offset the financial burden incurred when an insured or family member suffers a covered health event. We do not pay or reimburse hospitals, doctors or health care providers for the cost of medical care. Instead, our policies pay money to help out with the myriad expenses which befall families when someone is sick or injured. Aflac products are Excepted Benefits under HIPAA and,

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as you are well aware, are prohibited from being sold on the DC Exchange. Assessing excepted benefits to pay for exchanges is unfair to carriers and consumers who derive no benefit from exchanges.

Additionally, we endorse and agree with the legal arguments opposing the Exchange's authority to make the proposed assessments detailed by the American Council of Life Insurers and presented to you as part of this proceeding. Congress acknowledged the difference between excepted benefits and health benefit plans in prohibiting excepted benefits from being sold on health insurance exchanges. As a result, the ACA does not authorize exchanges to assess premiums ineligible to be written on exchanges. We also support the comments of America's Health Insurance Plans and the DC Insurance Federation in opposition to this proposal. These groups represent both supplemental writers and major medical insurers and have adopted positions calling for fundamental fairness in exchange funding proposals.

There are many important legal, public policy, consumer service, operational and efficiency issues facing your Exchange. Addressing these matters is important work and you have much to do to make the Exchange successful. We urge the Executive Board to withdraw the proposed rule and submit an assessment formula which recognizes the federal law and is fair to all insurers doing business in the District as an essential part of that effort.

Sincerely Yours,

Edward J Donahue, Jr.

2211 Congress Street
Portland, ME 04122
207 575 2211
www.unum.com

March 31, 2014

Mary Beth Senkewicz, Esq.
Associate General Counsel and Policy Advisor
DC Health Benefit Exchange Authority
1100 15th St NW; 8th Floor
Washington, DC 20005

RE: Proposed Subtitle D, Chapter 1. Health Carrier Assessments addition to Title 26: Insurance, Securities and Banking of the District of Columbia Municipal Regulations. – Health Benefit Exchange Authority Funding Assessment

Dear Ms. Senkewicz:

Unum Group, Inc. on behalf of its insuring subsidiaries (collectively "Unum"), respectfully submits these comments in opposition to the above-referenced proposal ("Proposal") by the DC Health Benefit Exchange (the "Exchange") to assess insurance premiums derived from "all health insurance risks originating in or from the District of Columbia." The Proposal was adopted by the Health Benefit Exchange Authority Executive Board on February 12, 2014 and submitted for approval of the District Council effective March 4, 2014.

The Proposal would establish an assessment on health insurance premiums pursuant to a formula based on "direct gross receipts" of insurers which would be derived from "all health insurance risks originating in or from the District" to fund the operations of the Exchange. This formula would directly assess a fee on health insurance products ineligible to be sold on the Exchange as well as major medical and dental insurance. This funding approach would be unique in the country and raises many legal, practical and fairness concerns for insurers, consumers and regulators. We maintain it is unfair to carriers and policyholders to assess fees on products that cannot be sold on the Exchange to pay for the operations of the Exchange.

Unum is a market leader in group and individual disability insurance and group long-term care insurance, as well as one of the nation's largest of supplemental health insurance products, none of which are health benefit plans or major medical coverage. Unum's products do not cover medical expenses, rather they provide protection from financial losses (i.e., lost income) when an insured or family member suffers a covered loss. Our products do not pay or reimburse hospitals, doctors or health care providers for the cost of medical

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care. Unum's products are Excepted Benefits under HIPAA and are prohibited from being sold on the DC Exchange pursuant to the Patient Protection and Affordable Care Act ("ACA").

Additionally, we endorse and agree with and incorporate the arguments and comments opposing the Exchange's authority to make the proposed assessments submitted to you as part of this proceeding by the American Council of Life Insurers and America's Health Insurance Plans. These groups represent insurers from a broad spectrum of the health insurance industry and have adopted positions calling for fundamental fairness in exchange funding proposals and have directly opposed the Authority's Proposal.

Assessing insurers based upon non-ACA products that may not be sold on the Exchange unfairly shifts the cost of the exchange from carriers whose products may be sold on the exchange to those whose products may not. Such an assessment is unfair and beyond the authority of the Exchange and the ACA, and we urge the Exchange Authority to withdraw the proposed rule and submit an assessment formula which recognizes the federal law and is fair to all insurers doing business in the District as an essential part of that effort.

Sincerely yours,

Charles P. Piacentini, Jr.
Vice President, State Legislative Affairs
Unum Group

Financial Security...for Life.

Gary Hughes
Executive Vice President & General Counsel

March 31, 2014

Ms. Mary Beth Senkewicz
DC Health Benefit Exchange Authority
1100 15th Street NW, Eighth Floor,
Washington, D.C. 20005

Re: Comments regarding the DC Health Benefit Exchange Proposed Health Carrier Assessment

Dear Ms. Senkewicz:

These comments are submitted on behalf of the American Council of Life Insurers (the "ACLI"). The ACLI is a national trade association with approximately 300 member companies representing more than 90 percent of the assets and premiums of the life insurance and annuity industry in the U.S. We appreciate the opportunity to submit comments to the DC Health Benefit Exchange Authority (the "Authority") on the proposed rulemaking (the "proposed rule") that would implement the Health Carrier Assessment (the "Fee"). However, ACLI asserts that the proposed rule is legally defective, and must be revised to comply with applicable District of Columbia statutes and Patient Protection and Affordable Care Act[1] (the "ACA") guidance regarding state-operated health insurance exchanges. As such, ACLI respectfully requests that the Authority withdraw and reconsider the proposed rule pending further study and review.

I. The Authority has Overreached its Statutory Assessment Power by Imposing a Fee on Issuers of Excepted Benefit Policies

The Authority was established as a requirement of Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011 (the "Establishment Act"), effective March 3, 2012.[2] The Authority's charge is to implement a health insurance benefit exchange program in the District of Columbia (the "DC Exchange") in accordance with the ACA, thereby ensuring access to quality and affordable health care to District of Columbia residents.

Section 4 of the Establishment Act[3] establishes the Health Benefit Exchange Authority Fund (the "Fund"), which will be the primary funding source for the DC Health Benefit Exchange. This section also vests the Authority with the power to raise revenue for the Fund. Specifically, § 4(e)(1) states:

> (e)(1) The Authority is authorized to charge, through rulemaking:
> (A) User fees;

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[1] 42 U.S.C. § 18001 et seq. (2010)
[2] D.C. Code §§ 31-3171.01, et. seq. (2012 Replacement).
[3] D.C. Code § 31-3171.03 (2012 Replacement)

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(B) Licensing fees; and
(C) Other assessments on *health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchange*. (emphasis added).[4]

A qualified health plan, as defined in the Establishment Act, is a "health benefit plan" that meets the certification requirements of § 1311(c) of the ACA and § 10 of the Establishment Act.[5] For this purpose, a "health benefit plan" that may eventually become certified as a "qualified health plan" is first defined in § 2(4)(A) of the Establishment Act[6], which states:

"Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Section 2(4) of the Establishment Act also details the types of coverage that are *excluded* from the definition of "health benefit plan", and thus may not be offered on the DC Exchange. Such plans are also beyond the regulatory reach of the Authority. Specifically, §§ 2(4)(B)-(E) of the Establishment Act provides (in part) that:

The term "health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or any combination thereof;
(ii) Liability insurance, including general liability insurance and automobile liability insurance; . . .
or

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) ... under which benefits for health care services are secondary or incidental to other insurance benefits.

Section 2(4)(C) further provides:

(C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance or are otherwise not an integral part of the plan...:

(i) Limited scope dental or vision benefits;
(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(iii) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

Additional non-health insurance policies are excluded under sections 2(4)(D) and (E), which state:

(D) The term "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance...:

[4] D.C. Code § 31-3171.03(e)(1) (2012 Replacement)
[5] D.C. Code § 31-3171.09 (2012 Replacement)
[6] D.C. Code §31-3171.01(5) (2012 Replacement)

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) The term "health benefit plan" does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

(i) Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq.; or

(iii) Similar supplemental coverage provided as coverage under a group health plan.[7]

This exclusionary language tracks the language of §2791(c) of the Public Health Services Act (PHSA),[8] which details the exclusion of certain insurance coverage. These benefits are generally referred to as "excepted benefits" for purposes of the ACA.

Under the ACA, the coverage listed above, collectively referred to as "excepted benefits" coverage, is not treated as "minimum essential coverage" under the ACA, and will not satisfy the ACA's individual mandate to maintain health insurance coverage.[9] As such, issuers of excepted benefit coverage, such as long-term care, disability, and fixed indemnity policies, are not required to comply with the ACA's health insurance market requirements and are also prohibited from participating in the federal and state exchanges.[10]

Despite language in the Establishment Act clearly carving excepted benefit plans and carriers <u>out</u> of the DC Exchange, the proposed rule attempts to re-capture excepted benefit coverage, but <u>only</u> for purposes of financing the DC Exchange. Section 100.1 of the proposed rule, states:

> The DC Health Benefit Exchange Authority ("Authority") shall assess annually, through a "Notice of Assessment," *each health carrier doing business in the District* with direct gross receipts of $50,000 or greater in the preceding calendar year an amount based on a percentage of its direct gross receipts for the preceding calendar year. (emphasis added)[11]

By issuing the proposed rule, the Authority ignores the plain language of the Establishment Act, which clearly limits its authority to impose fees to issuers of qualified health plans, which unambiguously excludes excepted benefit plans. Instead, the proposed rule uses the expansive term "health carrier" to cast an impermissibly broad net over the health insurance market, capturing a wide range of insurance entities for purposes of the fee, including carriers of disability, long-term care, and fixed indemnity coverage, none of which participate in or benefit from the DC Exchange.[12]

Simply stated, the Authority's enabling legislation does not authorize the proposed market-wide fee assessment on issuers of excepted benefits which are not "health benefit plans" or "qualified health

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[7] D.C. Code § 31-3171.01(5)(B)-(E) (2012 Replacement).
[8] 42 U.S.C. 300gg-91 (2012).
[9] Internal Revenue Code §5000A et.seq., as added by the ACA.
[10] Except, in limited instances, stand-alone dental plans.
[11] 61 D.C. Reg. 001741 (Feb. 28, 2014).
[12] D.C. Code § 31-3171.01(6) (2012 Replacement)

plans" under DC Exchange laws. The Authority's decision to impose the Fee on all "health carriers" is therefore an unlawful overreach of the Authority's statutory power. The Council of the District of Columbia (the "Council") did not grant the Authority assessment power with regard to excepted benefit plans or carriers under the Establishment Act, and such plans are therefore not subject to the regulatory and oversight power of the Authority. As such, the proposed rule is legally flawed, and cannot be finalized in the absence of an amendment drastically curtailing the scope of the Authority's assessment to those plans over which it has clear assessment jurisdiction.[13]

II. The Proposed Rule Impermissibly Conflicts with the Federal Law Governing State Exchanges

Federal law provides state exchanges with limited power to raise revenue. As such, the Authority's power to levy fees is regulated not only by the authority granted to the Authority by the Council, but also by the power granted to state exchanges under federal law through the ACA.

ACA § 1311(d)(5)(A) requires that state-operated exchanges must be financially self-sustaining no later than January 1, 2015, and specifically directs state exchanges to look to carriers *participating in the exchange* as a funding source:

> (5) FUNDING LIMITATIONS.—
> (A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—
> In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to *participating health insurance issuers*, or to otherwise generate funding, to support its operations (emphasis added).

Longstanding principals of statutory interpretation[14] dictate that the inclusion of the term "participating health insurance issuers" must be given its full effect. Accordingly, the entire statute must be read to imply that Congress intentionally restricted state exchanges to levying fees on *participating* health insurance issuers rather than *all* health insurance issuers (including issuers of excepted benefits), and that state attempts to "otherwise generate funding" should not include broad assessments on non-participating health carriers excluded from the main body of the funding statute. Therefore, by assessing an exchange fee against non-participating insurance issuers, the proposed rule conflicts with the statutory exchange funding provisions of the ACA.

Administrative guidance on public exchange standards issued by the Center for Medicare and Medicaid Services (CMS)[15] further suggests that the ACA should be interpreted as prohibiting state exchanges from compelling carriers of non-exchange products to fund exchange operations. In guidance issued in March 2013, CMS issued standards for programs that allow state exchanges to offer "ancillary" products that are not qualified health plans (QHPs) through a separate state program that would share resources and infrastructure with the state-based exchange.[16] In that guidance, CMS makes clear that "... Exchange user fees and assessments may not be used to support non-Exchange activities" and that

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[13] We note that the Authority's overreach could be corrected by simply amending the proposed rule to limit assessments to issuers of "qualified health plans" or "health benefit plans", as these terms are defined in the D.C. Official Code.

[14] The doctrine is generally referred to as the doctrine against surplusage, or *verba cum effectu sunt accipienda*, which dictates that courts should prefer a statutory interpretation that gives consequence to each word. *See Kungys v. U.S.*,485 U.S. 759, 779 (1998).

[15] Center for Medicare and Medicaid Services (through its Center for Consumer Information and Oversight (CCIIO)) is the Department of Health and Human Services sub-agency responsible for establishing exchange standards.

[16] Note that the Authority did not opt to offer ancillary products through a state program in connection with the CMS guidance.

"Exchange funds should not be co-mingled with the funds used to support the separate state programs facilitating enrollment in non-QHPs".[17] The guidance indicates that CMS interprets the ACA to draw a sharp distinction between funding earmarked for or generated by carriers of qualified health plans that will participate in the exchange, and funding sourced from "non-QHP" issuers that will not participate in the exchange, such as excepted benefit carriers. As such, the Authority's attempt to support the DC Exchange with co-mingled fees sourced from both qualified health plan carriers and carriers that do not offer qualified health plans on an exchange also conflicts with CMS's interpretation of ACA state exchange funding standards.

In fact, the District is the only state that interprets the ACA to allow an exchange to impose fees on non-participating carriers of excepted benefits and co-mingle those fees with state exchange funds. A survey of the 24 states operating state or federal-partnership exchanges in 2014 reveals that the Authority is the sole exchange entity that has attempted to fund its operations by assessing fees on carriers of excepted benefit plans not subject to ACA qualified health plan requirements.[18] This demonstrates that the proposed rule not only conflicts with federal law, but also conflicts with, the interpretation of the ACA's state exchange funding requirements as accepted by every other state, making the District a regulatory outlier.

The ACA's public exchange regulations provide that state exchange rules cannot interfere with federal law, nor may such rules conflict with, or prevent the application of, regulations issued by the Department of Health and Human Services (HHS).[19] By extending the DC Exchange assessment to issuers that do not participate in the exchange, the proposed rule conflicts with the ACA and applicable HHS funding standards for state exchanges, and applies ACA rules governing state exchange financing in a manner that is inconsistent with the interpretation adopted by all other state exchanges. Therefore, the proposed rule cannot be finalized in its current form.

III. Issuers of Excepted Benefits, Such as Disability, Long-term Care, and Fixed Indemnity Insurance, are not Health Plan Issuers, and Cannot Participate in the Exchange.

Both the ACA and District of Columbia law provide that issuers of excepted benefits are affirmatively *prohibited* from offering their products on a public exchange.[20] Issuers or excepted benefits are excluded from the DC Exchange because excepted benefit products are not considered "minimum essential coverage" for purposes of the ACA, and cannot be purchased by DC citizens in an effort to satisfy the ACA's individual mandate to purchase health insurance coverage. Thus, while the proposed rule subjects issuers of disability, long-term care, and similar excepted benefits coverage to the Fee alongside issuers of qualified health plans, excepted benefit carriers do not stand to benefit from the added revenue associated with the DC Exchange, because their products cannot be offered to DC residents through the Exchange. In addition, unlike carriers of qualified health plans, carriers of excepted benefits coverage will not have the opportunity to recoup Fee assessments through an anticipated increase in policyholder revenue associated with the ACA's insurance mandate.

Excepted benefit coverage is properly excluded from public health insurance exchanges, since disability, long-term care, and similar types of excepted benefits are financial products, not health insurance products. These excepted benefit plans do not provide payment for services rendered by doctors, hospitals, and other medical providers. Instead, these policies often pay benefits directly to the covered

[17] http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-2013.pdf (last visited March 27, 2014)
[18] https://www.statereforum.org/exchange-policy-decisions-chart (last visited March 27, 2014).
[19] 26 CFR §155.120(a).
[20] ACA 1311(d)(2), DC Code §31-3171.09.

individual (or his or her family) to cover day-to-day living expenses, such as mortgage payments, rent, and utilities, while the individual is unable to earn income due to illness, injury, or other incapacity. The coverage may also pay for training or other assistance needed to return to work. As such, these products are not sold as health coverage; instead, these benefits enable the policyholder to maintain financial independence in the face of circumstances that would otherwise jeopardize an individual's lifestyle and long-term savings.

Because excepted benefit carriers do not offer health insurance coverage, and because these carriers do not directly or indirectly benefit from the operation of the Exchange, they should not be required to finance the Exchange solely to generate revenue for an entirely separate segment of the insurance industry. Carriers of excepted benefits coverage will benefit from the operation of the DC Exchange no more than issuers of automobile collision coverage or property and casualty insurers. These carriers are properly excluded from assessment and regulation by the Authority because they have no connection to the comprehensive health insurance market. The same reasoning applies to carriers of excepted benefi coverage. Accordingly, excepted benefit issuers should be excluded from the Fee assessment. The proposed rule must be withdrawn and revised accordingly.

IV. The Proposed Rule Exposes the District of Columbia, the Council, and the Authority to a Substantive Legal Challenge.

If the proposed rule is not withdrawn and amended to comply with District of Columbia and federal law, carriers of excepted benefits and other coverage that is offered on the DC Exchange have cause to mount a legal challenge to the law on both procedural and substantive grounds.

The decision to fund the DC Exchange with a broad-based assessment was developed during closed-door working group sessions between the Authority and the Financial Sustainability Working Group (the Working Group), which consisted of selected "stakeholders" in the exchange community, including one member of the Authority's Executive Board and one member of the Standing Advisory Board. The insurance industry was represented on the Working Group by two health insurance issuers, both of whom offer qualified health plans. According to public records[21], excepted benefit issuers were not invited to participate in discussions regarding the market-wide assessment, were not represented on the Working Group, and were not offered the opportunity to vote on the decision to expand the fee assessment to excepted benefit carriers. However, in its final report, the Working Group opted to impose the Fee on the unrepresented class of excepted benefits carriers without forewarning or consent, thus mitigating the impact of the Fee on the carriers of qualified health plans that were invited to participate in the Working Group.

This "assessment without representation" sets a dangerous precedent within District of Columbia government, and lends itself to a legal challenge in order to protect District of Columbia citizens and business from future autocratic assessments. Furthermore, this ad-hoc assessment against excepted benefit carriers exposes ACLI members to similar undue and unlawful assessments in other jurisdictions operating state exchanges. These facts lend support to an action for injunctive relief under relevant case law, which requires a plaintiff to demonstrate: (1) there is a substantial likelihood the plaintiff will prevail on the merits; (2) the plaintiff is in danger of suffering irreparable harm during the pendency of the action; (3) more harm will result to the plaintiff from the denial of the injunction than will result to the defendant from its grant; and (4) the public interest will not be disserved by the issuance of an injunctive order.[22]

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[21] See, Meeting Materials and Recommendations of the Financial Sustainability Advisory Working Group: http://hbx.dc.gov/node/551202 (last visited March 28, 2014).

[22] *Sierra Club*, 670 A.2d at 361, *citing Wieck*, 350 A.2d at 387; *see also*, *Simpson v. Lee*, 499 A.2d 889, 892 (D.C. 1985).

Under District of Columbia law, such injunctive action would be obtained by filing a request for relief with the D.C. Superior Court.[23] Specifically, comments regarding Rule 65 of the D.C. Superior Court Rules of Civil Procedure state that "[i]n the case of any application for a temporary restraining order against the District of Columbia, an agency thereof, or an employee acting or purporting to act in his official capacity, the adverse party's attorney is, of course, the Corporation Counsel of the District of Columbia." As such, Rule 65 contemplates the filing of an injunction against governmental bodies of the District.

While ACLI members seek to avoid litigation in administrative matters, the grave circumstances surrounding the assessment of the Fee pursuant to the proposed rule warrant decisive action. In this case, such action may be necessary in order to protect existing member interests and forestall broader detriment to the District of Columbia insurance market and its citizens, who rely on the continued availability of disability, long-term care, and similar excepted benefits products in the District.

V. Conclusion

ACLI members support the Council's decision to operate an exchange for its citizens, and understand the need to find a self-sustaining revenue source for the DC Exchange. However, both federal and District of Columbia law dictate that the Authority must look solely to carriers of qualified health plans that are subject to the Authority's jurisdiction in order to fund the exchange. As such, carriers of excepted benefits, which are not qualified health plans and are prohibited from exchange participation, cannot be compelled to pay exchange assessment fees in the manner provided in the proposed rule.

ACLI therefore requests that the Authority withdraw the proposal to provide for a fee assessment, and propose an amended rule that does not subject issuers of excepted benefits to exchange fee assessments. Furthermore, while the substance of the comment addresses ACLI's concerns regarding the application of the Fee to excepted benefit carriers, we respectfully reserve the right to offer additional comments on the mechanics of the proposed rule, if necessary.

Sincerely,

Gary Hughes

[23] *See also, Friends of Tilden Park, Inc. v. District of Columbia*, 2000 WL 35483010, Dkt. No. 0008495-00 (D.C. Super 2000).

Prudential

Prudential Financial, Inc.
Catherine St. John, Director
Government Affairs
50 West State Street, Suite 1116, Trenton NJ 08608
Tel 877-315-1043 Fax 609 989-7045

March 31, 2014 Sent via email

Ms. Mary Beth Senkewicz
Associate General Counsel and Policy Advisor
DC Health Benefit Exchange Authority
1100 15th Street NW, 8th Floor
Washington, DC 20005

Re: DC Health Benefit Exchange
Proposed Health Carrier Assessment

Dear Ms. Senkewicz:

Prudential appreciates the opportunity to comment on the above referenced-rule proposal which sets forth a Health Carrier Assessment to fund the operation of the DC Health Benefit Exchange Authority. However, we believe the assessment rule overreaches the limits of the Exchange Authority's power by imposing an assessment on excepted benefit plans. In this regard, we respectfully offer the following comments:

The Authority has Overreached its Statutory Assessment Power by Imposing a Fee on Issuers of Excepted Benefit Policies

The Authority was established as a requirement of Section 3 of the Health Benefit Exchange Authority Establishment Act of 2011 (the "Establishment Act"), effective March 3, 2012.[1] The Authority's charge is to implement a health insurance benefit exchange program in the District of Columbia (the "DC Exchange") in accordance with the ACA, thereby ensuring access to quality and affordable health care to District of Columbia residents.

Section 4 of the Establishment Act[2] establishes the Health Benefit Exchange Authority Fund (the "Fund"), which will be the primary funding source for the DC Health Benefit Exchange. This section vests the Authority with the power to raise revenue for the Fund. Specifically, § 4(e)(1) states:

> (e)(1) The Authority is authorized to charge, through rulemaking:
> (A) User fees;
> (B) Licensing fees; and
> (C) Other assessments on *health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchange.* (emphasis added).[3]

[1] D.C. Code §§ 31-3171.01, et. seq. (2012 Replacement).
[2] D.C. Code § 31-3171.03 (2012 Replacement)
[3] D.C. Code § 31-3171.03(e)(1) (2012 Replacement)

A qualified health plan, as defined in the Establishment Act, is a "health benefit plan" that meets the certification requirements of § 1311(c) of the ACA and § 10 of the Establishment Act.[4] For this purpose, a "health benefit plan" that may eventually become certified as a "qualified health plan" is first defined in § 2(4)(A) of the Establishment Act[5], which states:

> "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Section 2(4) of the Establishment Act also details the types of coverage that are *excluded* from the definition of "health benefit plan", and thus are prohibited from participating in the DC Exchange. Such plans are also beyond the regulatory reach of the Authority. Specifically, §§ 2(4)(B)-(E) of the Establishment Act provide that:

> The term "health benefit plan" does not include:
>
> (i) Coverage only for accident or disability income insurance, or any combination thereof;
> (ii) Liability insurance, including general liability insurance and automobile liability insurance;
>
> or
>
> (viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) … under which benefits for health care services are secondary or incidental to other insurance benefits.
>
> (C) The term "health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate of insurance, or contract of insurance…:
>
> (i) Limited scope dental or vision benefits;
> (ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
> (iii) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.
>
> (D) The term "health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate of insurance, or contract of insurance…:
>
> (i) Coverage only for a specified disease or illness; or
>
> (ii) Hospital indemnity or other fixed indemnity insurance.
>
> (E) The term "health benefit plan" does not include the following if offered as a separate policy, certificate of insurance, or contract of insurance:

[4] D.C. Code § 31-3171.09 (2012 Replacement)
[5] D.C. Code §31-3171.01(5) (2012 Replacement)

(i) Medicare supplemental policy as defined in section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq.; or

(iii) Similar supplemental coverage provided as coverage under a group health plan.[6]

This exclusionary language tracks the language of §2791 of the Public Health Services Act (PHSA),[7] the primary statute governing the ACA's health insurance market forms. Under the ACA the coverage listed above, collectively referred to as "excepted benefits" coverage, is not treated as "minimum essential coverage" under the ACA, and will not satisfy the ACA's individual mandate to maintain health insurance coverage.[8] As such, issuers of excepted benefit coverage, such as long-term care, disability, and fixed indemnity policies, are not required to comply with the ACA's health insurance market requirements and are also prohibited from participating in the federal and state exchanges.[9]

Despite language clearly carving excepted benefit plans and carriers out of the DC Exchange, the proposed rule attempts to re-capture excepted benefit coverage, but only for purposes of financing the DC Exchange. Through the proposed rule, the Authority attempts to impose a fee on *all* health insurance carriers, including carriers of excepted benefits that are excluded from the DC Exchange and are outside of the regulatory jurisdiction of the Authority. Section 100.1 of the proposed rule, states:

> The DC Health Benefit Exchange Authority ("Authority") shall assess annually, through a "Notice of Assessment," *each health carrier doing business in the District* with direct gross receipts of $50,000 or greater in the preceding calendar year an amount based on a percentage of its direct gross receipts for the preceding calendar year. (emphasis added)[10]

By issuing the proposed rule, the Authority ignores the plain language of the Establishment Act, which clearly limits its authority impose fees to issuers of qualified health plans. Instead, the proposed rule uses the expansive term "health carrier" to cast an impermissibly broad net over the health insurance market, capturing a wide range of insurance entities for purposes of the fee, including carriers of excepted benefits and carriers not otherwise participating in or benefiting from the DC Exchange.[11]

Simply stated, the Authority's enabling legislation does not authorize the proposed market-wide fee assessment on issuers of excepted benefits which are not "health benefit plans" or "qualified health plans" under DC Exchange laws. The Authority's decision to impose the Fee on all "health carriers" subject to the District's insurance regulation is therefore an unlawful overreach of the Authority's statutory power. The Council of the District of Columbia (the "Council") did not grant the Authority assessment power with regard to excepted benefit plans or carriers under the Establishment Act and such plans are not subject to the regulatory and oversight power of the Authority. As such, the proposed rule

[6] D.C. Code § 31-3171.01(5)(B)-(E) (2012 Replacement)
[7] 42 U.S.C. 300gg-91(2012)
[8] Internal Revenue Code §5000A et.seq., as added by the ACA.
[9] Except, in limited instances, stand-alone dental plans.
[10] 61 D.C. Reg. 001741 (Feb. 28, 2014).
[11] D.C. Code § 31-3171.01(6) (2012 Replacement)

is legally flawed, and cannot be finalized in the absence of an amendment drastically curtailing the scope of the Authority's assessment.[12]

The Proposed Rule Impermissibly Conflicts with the Federal Law Governing State Exchanges

Federal law provides state exchanges with limited power to raise revenue. As such, the Authority's power to levy fees is regulated not only by the authority granted to the Authority by the Council, but also by the power granted to state exchanges under federal law by the ACA.

The ACA § 1311(d)(5)(A) requires that state-operated exchanges must be financially self-sustaining no later than January 1, 2015, and specifically directs state exchanges to look to carriers *participating in the exchange* as a funding source:

> (5) FUNDING LIMITATIONS.—
> (A) NO FEDERAL FUNDS FOR CONTINUED OPERATIONS.—
> In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to *participating health insurance issuers*, or to otherwise generate funding, to support its operations (emphasis added).

Longstanding principals of statutory interpretation[13] dictate that the inclusion of the term "participating health insurance issuers" must be given its full effect. Accordingly, the entire statute must be read to imply that Congress intentionally restricted state exchanges to levying fees on *participating* health insurance issuers rather than *all* health insurance issuers (including issuers of excepted benefits), and that state attempts to "otherwise generate funding" should not include broad assessments on non-participating health carriers excluded from the main body of the statue. As such, the proposed rule conflicts with the statutory exchange financing provisions of the ACA by imposing a fee on *all* health insurance issuers.

Administrative guidance on public exchange standards issued by the Center for Medicare and Medicaid Services (CMS)[14] further suggests that the ACA should be interpreted as prohibiting state exchanges from compelling carriers of non-exchange products to fund exchange operations. In guidance issued in March 2013, CMS issued standards for state exchanges that have chosen to offer "ancillary" products that are not qualified health plans (QHPs) through a separate state program that would share resources and infrastructure with a state-based exchange.[15] In that guidance, CMS makes clear that "… Exchange user fees and assessments may not be used to support non-Exchange activities" and that "Exchange funds should not be co-mingled with the funds used to support the separate state programs facilitating enrollment in non-QHPs".[16] The guidance indicates that CMS interprets the ACA to draw a sharp distinction between funding

[12] We note that the Authority's overreach could be corrected by simply amending the proposed rule to limit assessments to issuers of "qualified health plans" or "health benefit plans", as these terms are defined in the D.C. Official Code.

[13] The doctrine is generally referred to as the doctrine against surplusage, or *verba cum effectu sunt accipienda*, which dictates that courts should prefer statutory interpretation that gives consequence to each word. *See Kungys v. U.S.*,485 U.S. 759, 779 (1998).

[14] Center for Medicare and Medicaid Services (through its Center for Consumer Information and Oversight (CCIIO)) is the Department of Health and Human Services sub-agency responsible for establishing exchange standards.

[15] Note that the Authority did not opt to offer ancillary products through a state program in connection with the CMS guidance.

[16] http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-2013.pdf (last visited March 27, 2014)

earmarked for or generated by carriers of qualified health plans that will participate in the exchange, and funding sourced from "non-QHP" issuers that will not participate in the exchange, such as excepted benefit carriers. As such, the Authority's attempt to support the DC Exchange with co-mingled fees sourced from both qualified health plan carriers and carriers that do not offer qualified health plans on an exchange conflicts with CMS's interpretation of ACA state exchange funding standards.

In fact, the District is the only state that interprets the ACA to allow an exchange to impose fees on non-participating carriers of excepted benefits. A survey of the 24 states operating state or federal-partnership exchanges in 2014 reveals that the Authority is the sole exchange entity that has attempted to fund its operations by assessing fees on carriers of excepted benefit plans not subject to ACA qualified health plan requirements.[17] As such, the Authority's interpretation of the ACA's state exchange funding requirements conflicts with the interpretation accepted by every other state, and makes the District appear to be a regulatory outlier for ACA purposes.

The ACA's public exchange regulations provide that state exchange rules cannot interfere with federal law, nor may such rules conflict with, or prevent the application of, regulations issued by the Department of Health and Human Services (HHS).[18] By extending the DC Exchange assessment to issuers that do not participate in the exchange, the proposed rule conflicts with the ACA and applicable HHS funding standards for state exchanges, and applies ACA rules governing state exchange financing in a manner that is inconsistent with the interpretation adopted by all other state exchanges.

Issuers of Excepted Benefits, Such as Disability, Long-term Care, and Fixed Indemnity Insurance, are not Health Plan Issuers, and Cannot Participate in the Exchange.

Both the ACA and District of Columbia law provide that issuers of excepted benefits are affirmatively *prohibited* from offering their products on a public exchange.[19] Furthermore, excepted benefit products are not considered "minimum essential coverage" for purposes of the ACA, and DC citizens will not be required to purchase excepted benefits in order to satisfy the ACA's individual mandate to purchase health insurance coverage. Thus, while the proposed rule subjects issuers of disability, long-term care, and similar excepted benefits coverage to the Fee alongside issuers of qualified health plans, excepted benefit carriers do not stand to benefit from the added revenue associated with the DC Exchange, because our products cannot be offered to DC residents through the Exchange. In addition, unlike carriers of qualified health plans, carriers of excepted benefits coverage will not have the opportunity to recoup assessment of the Fee through an anticipated increase in policyholder revenue associated with the ACA's insurance mandate.

Excepted benefit coverage is excluded from public health insurance exchanges because excepted benefits are financial products, not health insurance products. Excepted benefit coverage such as disability insurance, long-term care coverage, and fixed indemnity plans do not provide payment for services rendered by doctors, hospitals, and other medical providers. Instead, excepted benefit plans often pay benefits directly to the covered individual (or his or her family) to cover day-to-day living expenses, such as mortgage payments, rent, and utilities, while the individual is unable to earn income due to illness, injury, or other incapacity. The coverage may also pay for training or other assistance needed to return to work. As such, these products are not sold as health coverage; instead, excepted disability, long-term care, and fixed indemnity coverage enables the policyholder to maintain financial

[17] https://www.statereforum.org/exchange-policy-decisions-chart (last visited March 27, 2014).
[18] 26 CFR §155.120(a).
[19] ACA 1311(d)(2), DC Code §31-3171.09,

independence in the face of circumstances that would otherwise jeopardize an individual's lifestyle and long-term savings.

We appreciate your time and consideration of our comments. Should you have any questions, or require additional if information please do not hesitate to contact me at 877-315-1043.

Sincerely,

Catherine St. John

DC Fiscal Policy Institute

March 31, 2014

Mary Beth Senkewicz,
DC Health Benefits Exchange
1100 15th Street, NW, Eighth Floor,
Washington, D.C. 20005
mary.senkewicz@dc.gov

Dear Ms. Senkewicz,

Thank you for the opportunity to provide comments on the Proposed Assessment Rule for Financial Sustainability for the DC Health Benefit Exchange Authority.

The proposed rule adds Subtitle D to Title 26, Insurance, Securities, and Banking, of the District of Columbia Municipal Regulations. It would create an assessment on each health carrier in the District of Columbia with direct gross receipts of $50,000 or greater, with those funds dedicated to support the operations of the Authority. The assessment is based on a percentage of the carrier's direct gross receipts in the previous calendar year and is expected to be 1 percent or less in the first year.

The proposed rule also defines "health carrier" as "entities [...] that contracts or offers to contract, to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services",[1] including major medical insurers selling on and off the exchange, managed care organizations, and HIPAA-excepted benefit products.

DC Fiscal Policy Institute supports a sustainable financing mechanism for the DC Health Benefit Exchange Authority and was part of the working group that recommended the health carrier assessment. The proposed assessment has several advantages.

First, by having a broad assessment base that includes all types of health products, health carriers would face the lowest possible carrier-based assessment rate, and no type of health plan (i.e. exchange vs. non-exchange, small group vs. large group) would be disproportionately impacted or preferred. There is a logic to require all carriers to pay the assessment because all carriers will benefit from the exchange. Carriers that sell plans on the exchange will benefit from a fully-funded and well-functioning exchange that will help drive consumer demand for their products. Carriers selling HIPAA-excepted products, including long-term care and disability insurance, will also benefit as more residents gain health coverage through the exchange -- lowering risk and improving profitability of their products.

[1] D.C. Official Code § 31-3171.01(6).

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Second, a broad-based assessment will keep premiums as low as possible for consumers. Carriers will likely shift the costs of an assessment to consumers through premiums, but if the assessment is broad, the premium of each individual plan will be affected minimally.

Third, raising the assessment on plans sold both inside and outside of the exchange will also mean that large employer plans are not preferentially priced when compared to exchange plans for individuals, families, and small employers.

Finally, a financially sustainable exchange means that consumers will continue to benefit from a timely, reliable, and well-functioning portal for health coverage, as well as a robust network of consumer assistance.

Thank you for your time and consideration. Please feel free to contact me at rivers@dcfpi.org or 202-325-8821 if you have any questions.

Sincerely,

Wes Rivers
Policy Analyst
DC Fiscal Policy Institute
202-325-8821
http://www.dcfpi.org

Senkewicz, MaryBeth E. (DCHBX)

From: DuPont, Eric <edupont@metlife.com>
Sent: Monday, March 31, 2014 5:27 PM
To: Senkewicz, Mary8eth E. (DCHBX)
Cc: Joann Waiters (joannwaiters@acli.com)
Subject: Health Benefit Exchange Authority Proposed Health Carrier Assessment

Ms. Mary Beth Senkewicz
Associate General Counsel and Policy Advisor
Health Benefit Exchange Authority
1100 15th Street NW, Eighth Floor
Washington, DC 20005

Dear Ms. Senkewicz:

Thank you for the opportunity to comment on the proposed rulemaking that would implement the Health Carrier Assessment fee. Metropolitan Life Insurance Company (**MetLife**) submits this letter to express our strong opposition to the broad reach of the assessment to include insurers not participating in the District of Columbia Health Benefit Exchange.

The federal insurance and market reforms established under the Affordable Care Act (ACA) apply to comprehensive, major medical coverage. The ACA follows the approach established under HIPAA, excluding excepted benefit products from these requirements. MetLife offers a wide variety of HIPAA excepted benefits. Federal agencies have acknowledged this intent regarding ACA insurance and market reforms, and most states that have developed exchanges exclude HIPAA excepted benefit products from the funding mechanism. In addition, Sec. 1311 of the ACA specifically limits the types of coverage offered in Exchanges to qualified health plans and stand-alone dental plans providing "essential" pediatric dentals benefits, and federal guidance confirms that no other types of coverage may be offered through Exchanges.

MetLife requests that the language describing the Health Carrier Assessment fee be clarified to assess participating qualified health plans and dental plans in alignment with the language in the existing Exchange statutes rather than imposing the assessment on all accident and sickness insurers.

MetLife shares your goal for a successful, financially sustainable health insurance market and stands ready to work with the DC Health Benefit Exchange Authority and the DC City Council to find a solution that will ensure a robust marketplace. However, MetLife has serious concerns with the proposal's imposition of an assessment on all insurers to fund the Exchange.

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In addition, MetLife stands strongly in support of the ACLI comment letter dated March 31, 2014, on this same subject.

Thank you for considering our comments. Please let me know if you have questions or wish to discuss MetLife's comments.

Sincerely,

Eric C. DuPont
Vice President and Government Relations Counsel
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Joseph DeCresce
Second Vice President and Counsel

VIA ELECTRONIC MAIL

March 31, 2014

Mary Beth Senkewicz
Associate General Counsel and Policy Advisor
District of Columbia
Health Benefit Exchange Authority
1100 15th Street NW
Eighth Floor
Washington, DC 2005

RE: Comments regarding the DC Health Benefit Exchange Proposed Health Carrier Assessment

Dear Ms. Senkewicz:

The Guardian Life Insurance Company of America joins in support of the letter that you have received from the American Council of Life Insurers concerning the proposed Health Benefit Exchange Fee.

As set out in the ACLI's letter the Authority has overreached its statutory assessment power by imposing a fee on issuers of excepted benefit policies.

The Proposed Rule impermissibly conflicts with the federal law governing state exchanges.

Issuers of excepted benefits, such as Disability, Long-term Care, and Fixed Indemnity Insurance, are not Health Plan Issuers, and cannot participate in the Exchange.

By extension, standalone dental carriers will be assessed a fee under this proposal even though at present these products are not available on the Exchange.

The Guardian supports the Council's decision to operate an exchange for its citizens, and understand the need to find a self-sustaining revenue source for the DC Exchange. However, both federal and District of Columbia law dictate that the Authority must look solely to carriers of qualified health plans subject to the Authority's jurisdiction in order to fund the exchange. As such, carriers of excepted benefits, which are not qualified health plans and are prohibited from exchange participation, cannot be compelled to pay exchange assessment fees in the manner provided in the proposed rule.

The Guardian Life Insurance Company of America 7 Hanover Square, New York, NY 10004-2616
tel: 212.598.8388 fax: 212.919.2711 email: joseph_decresce@glic.com

GUARDIAN

Guardian supports ACLI's request that the Authority withdraw the proposal to provide for a fee assessment, and propose an amended rule that does not subject issuers of excepted benefits to exchange fee assessments. Furthermore, while the substance of the comment addresses ACLI's concerns regarding the application of the Fee to excepted benefit carriers, we respectfully reserve the right to offer additional comments on the mechanics of the proposed rule, if necessary.

Respectfully,

Joseph P. DeCresce

cc: Joann Waiters