Comments on Financial Sustainability Proposed Rule

Received by Jan. 30, 2014

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

January 30, 2014

Ms. Mila Kofman, Executive Director
DC Health Benefits 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. Kofman:

Thank you for the opportunity to comment on the District of Columbia Health Benefit Exchange Authority's Assessment Rule Informal Comment Discussion Draft.

The Discussion Draft proposes the creation of a new Subtitle D, Health Benefit Exchange, to be added to Title 26 of District of Columbia Municipal Regulations. This new subtitle would allow the DC Health Benefits 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 Discussion Draft indicates that all carriers that have $50,000 or more in DC-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 and appropriate to require all insurers of health risks in DC 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 DC 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 Exchange 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 DC's 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.

Finally, the Discussion Draft states that health carriers would be required to pay the assessment within 10 business days. Kaiser Permanente does not believe 10 days is a reasonable amount of time to complete such a transaction and requests that the payment window be expanded to at least 30 days, as is customary in most business transactions.

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

2101 East Jefferson Street
Rockville, Maryland 20852

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From: KMcCown@ameritas.com [mailto:KMcCown@ameritas.com]
Sent: Thursday, January 30, 2014 5:30 PM
To: Comments, FSR (DCHBX)
Subject: Assessment Rule Informal Comment Discussion Draft - Proposed Addition to the District of Columbia Municipal Regulations

Ameritas
fulfilling life

January 30, 2014

District of Columbia Health Benefit Exchange Authority (DCHBX)
1100 15th Street, NW, 8th Floor
Washington, DC 20005
Sent electronically via fsr.comments@dc.gov

RE: Assessment Rule Informal Comment Discussion Draft - Proposed Addition to the District of Columbia Municipal Regulations
Dear Exchange Authority Staff:

On behalf of Ameritas Life Insurance Corp, a licensed insurer providing stand-alone dental and vision plans in the District of Columbia, we are writing for clarification on the Assessment Rule Informal Comment Discussion Draft and the proposed addition to the District of Columbia Municipal Regulations. We question the applicability of the insurer assessment for support of the exchange being applied to all health carriers.

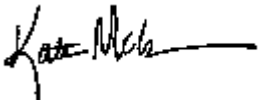
It is our understanding that the District of Columbia Health Benefit Exchange Authority has statutory authority to levy assessments supporting the exchange per D.C. Official Code § 31-3171.03(e)(1)(c), which states the assessment would apply to *"…health carriers selling qualified dental plans or qualified health plans in the District, including qualified health plans and qualified dental plans sold outside the exchanges.*"

In the proposed addition to the District of Columbia Municipal Regulations, we note that the new Chapter 99, "Definitions," under 9900.1 uses the definition of "Health carrier" as D.C. Official Code § 31-3171.01(6). This definition would include dental and vision carriers that are not considered qualified health or dental plans.

We believe this is an oversight as it appears application of the assessment to non-qualified plans would be outside of the codified authority for the assessment. Since at this time dental and vision carriers are not eligible to participate in the DC Exchange, it would seem that health carriers offering dental and vision benefits should not be subject to this fee. We respectfully request clarification to be given in the final regulations.

We welcome any opportunity to meet or speak with you and/or any appropriate staff to provide additional information or clarification. Please do not hesitate to call me at (402) 309-2019 or email kmccown@ameritas.com.

Sincerely,



Kate McCown, Director, Group Compliance – Health Care Reform

Kate McCown, PCS | **Ameritas Group** | Director, Group Compliance – Health Care Reform
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Mila Kofman, Executive Director
DC Health Benefits Exchange
1100 15th Street, NW, 8th Floor
Washington, DC 20005
Re: District of Columbia Health Benefits Exchange Proposed Assessment Rule

Dear Ms. Kofman,

On behalf of the District of Columbia Association of Health Plans (DCAHP), I am writing to comment on the Assessment Rule Informal Comment Discussion Draft (Discussion Draft) that was released on January 14, 2014, by the District of Columbia Health Benefit Exchange Authority (Authority) regarding the proposed funding system to ensure the sustainability of the District of Columbia Health Benefits Exchange, DC Health Link.

DCAHP consists of six (6) Managed Care Organizations (MCOs), including Medicaid and Commercial member plans that provide high quality, cost effective health care coverage to over 200,000 District of Columbia residents. During its history, the Association has served as a partner with the District and other stakeholders in developing an efficient and effective healthcare delivery system.

Most recently, DCAHP and its member plans have been actively engaged in the District's efforts to implement the federal mandates of the federal Affordable Care Act (ACA). In that regard, representatives of our member plans have participated on all of the Working Groups advising the DC Health Benefit Exchange. In short, our member plans have sought to help the District develop the most effective, efficient and accessible Exchange possible.

DCAHP therefore appreciates the opportunity to review and comment on the Authority's Discussion Draft.

The Discussion Draft proposes the creation of a new Subtitle D, Health Benefit Exchange, to be added to Title 26 of the District of Columbia Municipal Regulations. This new subtitle would allow the Authority to annually assess each health carrier doing business in the District a gross receipts tax in a percentage amount to be specified annually as necessary to support the operations of the Authority.

Assessment:

As you are aware commercial health plans actively participated in the DC Exchange Authorities Financial Sustainability Working Group. During Working Group meetings, a number of DCAHP commercial member plans argued for a broad-based funding mechanism. While we applaud the DC Exchange Authority for proposing a funding methodology that is fairly broad-based, DCAHP commercial members believe the base for the assessment should be expanded even further. DCAHP requests that the DC Exchange Authority reconvene the Financial Sustainability Working Group in 2015, to identify additional funding sources including general fund revenues.

DCAHP encourages the Authority to leverage Medicaid Federal matching dollars to the extent the Exchange handles Medicaid/CHIP administrative functions and/or authorizes Navigators to assist with enrollment into those programs as well as secure District general fund revenues to support the Exchange.

Finally, the draft proposal does not include any details regarding the rate of the assessment. DCAHP also recommends that the final rule establish 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. Because the Exchange is going to be funded by a tax on insurer

DCAHP recommends that Carriers be allowed at minimum thirty (30) days to pay the assessment rather than the ten (10) business day deadline noted in the proposed rule.

Additionally, DCAHP recommends that 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.

Start of Assessment: DCAHP interprets the proposed regulations as requiring the assessment to be applied initially in calendar year 2015. The Department of Insurance, Securities and Banking have already approved health carriers' rates for the entire 2014 calendar year, 45 CFR § 144.103, which do not include or reflect the assessment. Moreover, additional funding in 2014 is not needed as the Center for Consumer Information & Insurance Oversight has fully funded the Authority's operations through December 31, 2014 through a Level 2 Establishment Grant (as supplemented June 13, 2013). *See* Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges, http://apply07.grants.gov/apply/opportunities/instructions/oppIE-HBE-12-001-cidIE-HBE-12-001-015353-instructions.pdf. DCAHP therefore requests that the proposed regulations be modified to clarify that the assessment will not begin until 2015.

Timing of Assessment: DCAHP recommends that proposed § 26-100.01 be modified to indicate when during the year the Authority will issue a Notice of Assessment. This will ensure annual consistency and stability in the Authority's financing and also enable carriers to plan for when the assessment must be paid to the Authority.

Scope of Assessment: The proposed regulations provide that the Authority will seek an assessment on a health carrier's membership fees and net premium receipts. DCAHP supports this approach, but wishes to clarify that premiums attributable to the Federal Employee Health Benefits Program ("FEHBP") that Carriers administer should not be included in such assessment. *See* 5 USC § 8909(f). It is established that States or localities cannot impose assessments on that federal program, and FEHBP is not subject to the existing D.C. premium tax. DCAHP assumes that this is consistent with the proposed regulations' intent, but thought it prudent to make the issue clear.

Thank you again for the opportunity to provide feedback. DCAHP and our member plans have noted our concerns with the proposed assessment to fund the Exchange as it is currently written. We therefore appreciate your time and consideration of our comments and recommendations. 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 (202-250-4958) or by email (dwwdc1@gmail.com).

David W. Wilmot

Executive Director

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Tonya Vidal Kinlow
Vice President
Government Affairs

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Fax 301-470-3751

CareFirst BlueCross BlueShield

January 30, 2014

VIA EMAIL (assess@dc.gov)

District of Columbia Health Benefit Exchange Authority
1100 15th Street, NW, 8th Floor
Washington, DC 20002

Re: DC Health Benefit Exchange Authority ("Authority") Assessment Proposed Rule

Dear Sir or Madam:

I write on behalf of CareFirst BlueCross Blue Shield ("CareFirst") and in response to the Authority's proposed regulations, new Subtitle D, Health Benefit Exchange, Title 26, Chapter 1, "Health Carrier Assessments" and Chapter 99, "Definitions". CareFirst appreciates the opportunity to provide feedback to the Authority regarding the proposed regulations.

Start of Assessment: CareFirst interprets the proposed regulations as requiring the assessment to be applied initially in calendar year 2015. The Department of Insurance, Securities and Banking has already approved health carriers' rates for the entire 2014 calendar year, 45 CFR § 144.103, which do not include or reflect the assessment. Moreover, additional funding in 2014 is not needed as the Center for Consumer Information & Insurance Oversight has fully funded the Authority's operations through December 31, 2014 through a Level 2 Establishment Grant (as supplemented June 13, 2013). *See* Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges, http://apply07.grants.gov/apply/opportunities/instructions/oppIE-HBE-12-001-cidIE-HBE-12-001-015353-instructions.pdf. CareFirst therefore requests that the proposed regulations be modified to clarify that the assessment will not begin until 2015.

Timing of Assessment: CareFirst recommends that proposed § 26-100.01 be modified to indicate when during the year the Authority will issue a Notice of Assessment. This will ensure annual consistency and stability in the Authority's financing and also enable carriers to plan for when the assessment must be paid to the Authority.

Scope of Assessment: The proposed regulations provide that the Authority will seek an assessment on a health carrier's membership fees and net premium receipts. CareFirst supports this approach, but wishes to clarify that premiums attributable to the Federal Employee Health Benefits Program ("FEHBP") that CareFirst administers should not be included in such assessment. *See* 5 USC § 8909(f). States or localities cannot impose assessments on that federal program, and FEHBP is not subject to the existing D.C. premium tax. We

assume that this is consistent with the proposed regulations' intent, but thought it prudent to make the issue clear.

Thank you for the opportunity to comment on the above proposed regulations. If you have any questions, please feel free to contact me.

Sincerely,

Tonya Vidal Kinlow

cc: Brendan Rose, Plan Management Program Manager (Brendan.Rose@dc.gov)

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deltadentalins.com

January 29, 2014

SENT VIA EMAIL
Mary Beth Senkewicz
Associate General Counsel and Policy Advisor
Health Benefit Exchange Authority
marybeth.senkewicz@dc.gov

RE: District of Columbia Health Benefit Exchange Authority Informal Assessment Rule

Dear Ms. Senkewicz:

On behalf of Delta Dental, I am writing to comment on the Assessment Rule Informal Comment Discussion Draft (Discussion Draft) released on January 14, 2014, regarding a funding methodology to ensure the sustainability of the District of Columbia health benefits exchange, DC Health Link item concerns applicable user fees assessed against qualified health plans (QHP) and qualified dental plans (QDP).

The Discussion Draft proposes the creation of a new Subtitle D, Health Benefit Exchange, to be added to Title 26 of District of Columbia Municipal Regulations. This new subtitle would allow the DC Health Benefits Exchange Authority (DCHBX) to annually assess each health carrier doing business in the District a gross receipts tax in a percentage amount to be specified annually as necessary to support the operations of the Authority.

As we understand, the DCHBX's current approach would base a user fee assessment on a percentage of the carrier's premium market share. The actual percentage of the assessment would be calculated based on a projection of the operating expenses of the Exchange and the previous year's total health insurance premium dollars. This percentage could therefore increase or decrease in percentage from year to year. Further, this assessment would apply for Qualified Dental Plans (QDPs), also based on premium market share, including outside Exchange business and individual, small group and large group business.

First, we fundamentally agree that any participating QDPs should be assessed user fees to help fund the District's Exchange. And we commend you on the idea that the application of the assessment should be done in proportion to a product's written/paid premium, which automatically adjusts so that each participating carrier pays in equal proportion to their book of business.

While we agree with the fundamentals, we also have two concerns:

1. The Exchange Authority is applying the assessment, its purpose to fund the exchange, to QDP plans that have for the most part been disallowed entry into the DC Health Link ("Exchange"). As we have stated in previous comment letters, without a requirement for at least a few QHPs to offer medical without dental inside the Exchange, there is no viable market for QDPs offering pediatric dental in compliance with the Affordable Care Act (ACA). The result is that the assessment is being applied to us and other standalone dental plans in the District, while the Exchange simultaneously denies us the opportunity to sell ACA-compliant pediatric dental in OR outside the exchange in the non-group and small group markets.

2. We must oppose any assessment on QDPs outside of the Exchange, as these plans reap none of the advantages or administrative functions provided by the Exchange. It makes sense to assess fees to issuers inside the Exchange because the Exchange is both marketing and facilitating the sale of products with the advantage of federal subsidies to improve their affordability. However, outside Exchange issuers do not receive any benefit from using the Exchange and must bear the full administrative burden of their products. Thus, fees applied outside will raise the pricing of those products without any return benefit for the consumer. QDP products sold outside the Exchange should be exempt from any assessment or fees charged to finance the Exchange. This will protect the affordability of coverage outside the Exchange and provide small businesses and families in the District with additional avenues through which to purchase and/or retain their existing coverage.

We would welcome any opportunity to meet or speak with you and/or any appropriate staff to discuss these matters. Please know that we stand ready to help when it comes to implementing the dental benefit provisions of the health care reform law.

If you have any questions, please do not hesitate to call me at (415) 972-8418.

Sincerely,

Jeff Album
Vice-President, Public and Government Affairs

Cc: Mila Kofman, Executive Director
DC Health Link

Delta Dental of the District of Columbia
Administrative Office
One Delta Drive
Mechanicsburg, PA 17055-6999

Administrative: 800-471-7091
Customer Service: 800-932-0783
TTY/TDD: 888-373-3582

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AmeriHealth
DISTRICT OF COLUMBIA

January 30, 2014

Mila Kofman, Executive Director
District of Columbia Health Benefit Exchange
Authority 1100 15th Street, NW Eighth Floor
Washington, DC 20005

Re: Comments on Proposed Rule for Collection of Assessments to Make the Health Benefit Exchange Authority Financially Self-Sustaining by January 1, 2015

Dear Ms. Kofman:

On January 16, 2014, the District of Columbia Health Benefit Exchange Authority ("Authority") issued a proposed rule for the collection of assessments that will be used to assure the financial self-sustainability of the Authority by January 1, 2015. The proposed rule would add a new chapter to Title 26 of the District of Columbia Municipal Regulations, titled "Health Carrier Assessments." The Authority requested public comments on the proposed rule by the close of business on January 30, 2014. This letter

responds to that request.

AmeriHealth Caritas is the nation's leader in health care solutions for the underserved and chronically ill, impacting the lives of nearly 5 million individuals nationwide. Our goal is to provide responsible managed care solutions, including Medicaid, Medicare, and CHIP—plus pharmacy benefit management, behavioral health and administrative services.

At AmeriHealth District of Columbia (DC), we are committed to providing our members with access to quality health care and outstanding Member Services. We have a 30-year history of serving Medicaid communities and utilize our longstanding community ties to deliver the best in Medicaid managed care for the District of Columbia. We are the largest Medicaid Managed Care Organization (MCO) in the District of Columbia with more than 100,000 members. However, since AmeriHealth DC does not participate in the District of Columbia Health Benefit Exchange program, it should not be included in the proposed assessment fee.

The Patient Protection and Affordable Care Act ("ACA") was enacted on March 23, 2010 and provides the most significant and comprehensive reform of the U.S. healthcare system in several decades. See Pub.L. 111-148; Pub.L. 111-152. Among other things, the law provides incentives for individuals without health insurance coverage to select qualified health plans through newly created health benefit exchanges. The ACA envisions that each State will establish a health benefit exchange, or that the federal government will provide for the establishment of statewide exchanges in states that fail to act.

The ACA requires that each health benefit exchange be self-sustaining after an initial start-up period. The law states:

> "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." ACA § 1311(d)(5)(A) (emphasis added).

In 2011, the District of Columbia enacted the "Health Benefit Exchange Authority Establishment Act" ("D.C. Act"). See D.C. Code § 31-3171.01 et seq. The D.C. Act authorized the creation of the Authority, which is the primary entity responsible for

implementing the health benefit exchange provisions of the ACA in the District. Section 4(e)(1) of the D.C. Act authorized the Authority to collect "User fees," "Licensing fees," and "[o]ther 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." D.C. Code § 31-3171.03(e)(1). "Qualified health plans" and "qualified dental plans" are defined in the D.C. Act as those that have been certified by the Authority. To become qualified, such plans must seek certification from the Authority and meet an extensive list of criteria, many of which are required by the ACA. Once certified, these plans are eligible to offer products on the exchange.

The proposed rule is intended to implement Section 4(e)(1) of the D.C. Act. However, the proposed rule calls for the annual assessment of all "health carriers," based on "a percentage of its direct gross receipts for the preceding calendar year." The new assessments under the proposed rule presumably apply to all health carriers, regardless of whether they offer plans that have been certified by the Authority and are eligible to participate in the health benefits exchange, or have even sought to be certified by the Authority. For the following reasons, AmeriHealth DC does not believe that this proposed broad application of the assessment is prudent or authorized.

The proposed rule is contrary to the intent of the ACA.

As noted, the ACA requires States to assure that exchanges are self-sustaining and allows for assessments or user fees to be charged to participating health insurance issuers. This language explicitly limits the authority to impose assessments to health insurance issuers that are participating in the health benefit exchange in that jurisdiction. Although the language authorizes States to "otherwise generate funding," interpreting this phrase to suggest that States should assess non-participating health insurance issuers would render the earlier part of the statutory provision meaningless. To that end, we believe that this is an implausible reading of Congressional intent. It is far more plausible that the "otherwise generate funding" phrase in the ACA refers to the other more common sources of funding included in the D.C. Act, such as income from investments, interest, legal collections, donations, and grants. It is illogical to assume that Congress intended for non-participating health insurance issuers to be assessed.

The Authority lacks statutory authorization under the D.C. Act to assess health carriers that do not offer qualified health plans or qualified dental plans.

The D.C. Act is even more explicit than the ACA on this matter. It only allows assessments to be collected on "health carriers selling qualified dental plans or qualified health plans." See D.C. Code § 31-3171.03(e)(1) (emphasis added). By attempting to impose assessments on all health carriers, the proposed rule extends beyond the authority granted by the statute. Any further rulemaking proposals must limit assessments only to those health carriers that have sought and obtained approval to sell qualified plans.

Additionally, the Authority cannot use the statutory authority to impose "user fees" or "license fees" as a justification for imposing new burdens on health carriers. There is a well-established body of law, including U.S. Supreme Court decisions, regarding the constitutional limitations on user fees. Any such fee must be related to the jurisdiction of the regulator, and the fee must bear some relationship to the benefit being bestowed upon the regulated entity. Although this particular legal issue is not raised by the proposed rule, it is clear that any attempts in a subsequent regulation to impose user fees on non-participating health benefits issuers would also give rise to substantial legal concerns.

The breadth of the proposed rule is excessive and unprecedented.

As noted above, AmeriHealth Caritas serves nearly 5 million individuals nationwide, and the District is the only jurisdiction in which such a broad assessment has been proposed. In other states where the company operates a Medicaid MCO, health exchanges have assessed fees only on qualified health plans or dental plans, have imposed PMPM ("per member per month") assessments based on enrollment within the exchange, and have developed other exchange- related revenue sources such as charging for advertising on the exchange web portal. We are unaware of any other jurisdiction that is seeking to fund the administration of a statewide exchange by imposing fees or assessments on health carriers that participate solely in the Medicaid program.

Imposing assessments on a Medicaid MCO contravenes the intent of the ACA.

By seeking to impose an assessment on a Medicaid MCO that does not participate in the exchange, the proposed rule effectively adds costs to the program that serves the lowest income individuals and families in the District in order to fund an exchange that serves those at 138percent of the federal poverty level and higher. It is difficult to imagine that this was the intent of Congress is passing the ACA or of the D.C. Council in passing the D.C. Act.

Moreover, consider that "premium" revenues for a Medicaid MCO are provided by government programs. AmeriHealth DC neither offers a product on the District of Columbia Health Benefit Exchange nor offers any commercial insurance product in the District. To that end, any funds extracted from AmeriHealth DC would not further the goal to have the District of Columbia Health Benefits Exchange be "self-sustaining," as the fees paid by AmeriHealth DC would be originating from the District of Columbia Department of Health Care Finance. Assessing a fee such as the one proposed would trigger an actuarial revaluation that would ultimately result in an adjustment to the capitation rate paid to AmeriHealth DC by the Department of Health Care Finance. As such, the fee would amount to a government subsidy of the Health Insurance Exchange, thereby undermining the goal of self-sustenance.

Thank you for the opportunity to provide feedback. DC Association of Health Plans has noted our concerns with the proposed assessment to fund the Exchange as it is currently written. We appreciate your time and consideration of our comments and recommendations. If you have any questions or would like additional clarification of these comments, please feel free to contact me directly on (202) 326-8741.

Sincerely,

Karen Dale
Executive Director
AmeriHealth District of Columbia

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MetLife®

January 30, 2014

Mila Kofman, Executive Director
DC Health Benefits Exchange 1100
15th Street, NW, 8th Floor
Washington, DC 20005

Re: District of Columbia Health Benefits Exchange Health Carrier Assessment Comments

Dear Ms. Kofman,

I am writing on behalf of Metropolitan Life Insurance Company ("MetLife") to offer comments in response to the Assessment Rule Informal Comment Discussion Draft ("Assessment Rule") released on January 14, 2014, regarding a funding mechanism to ensure the sustainability of the District of Columbia Health Benefits Exchange, DC Health Link. MetLife offers various non-medical health insurance products in the District of Columbia, including dental, vision, long-term care, disability, critical illness, hospital indemnity, and accident insurance.

The Assessment Rule proposes Subtitle D, Health Benefit Exchange, to be added to Title 26 of District of Columbia Municipal Regulations. Subtitle D would allow the District of Columbia Health Benefit Exchange Authority (the "Authority") to annually assess 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.

MetLife provides the following comments on proposed Subtitle D:

I. Authority should delay application of the Assessment Rule for dental carriers

The Assessment Rule would require that all dental carriers, whether or not the dental carrier is a Qualified Dental Plan ("QDP"), be subject to the annual assessment to fund the DC Health Link. As noted in a letter to the Authority by the National Association of Dental Plans ("NADP") dated December 6, 2013, all Qualified Health Plans ("QHP") which applied to provide medical coverage on DC Health Link embedded pediatric dental. As such, despite MetLife's certification as a QDP in 2014, we are not a viable option for purchase on the DC Exchange. The Authority should delay the application of the Assessment Rule to dental carriers until QDPs have an opportunity to sell Affordable Care Act ("ACA") compliant pediatric dental plans on DC Health Link. Forcing an assessment on dental carriers that are not yet generating premiums in the DC Health Link will cause dental carriers to leave the market and will not be a steady source of revenue for the Authority as expected from the Assessment Rule.

II. Clarification needed on applicability of assessment on other lines of business

MetLife offers a full suite of products in the District of Columbia and as currently drafted; it is unclear whether certain products offered by MetLife would be annually assessed to fund the DC

Health Link. We request that the Authority confirm that the Assessment Rule would not apply to fixed indemnity products, such as critical illness, hospital indemnity, and accident that pay a fixed amount per covered illness or event. Additionally, we request the Authority clarify that the definition of "direct gross receipts" does not include long term care or disability insurance.

If it is intended for these products to be within the definition of "health carrier" and as such assessed the annual fee to fund the DC Health Link, MetLife believes it is inappropriate from a public policy perspective to include premiums from benefit products that are not required to comply with the ACA or have any opportunity to be offered on DC Health Link.

III. Undefined assessment amount causes difficulties in pricing

The Assessment Rule states that the Authority shall adjust the assessment rate each year and that the amount assessed shall not exceed reasonable projections regarding the amount necessary to support the operations of the Authority. In essence, the assessment rate is an open-ended assessment amount that will vary each year rather than a set percentage of premium amounts. The fluctuation in the assessment rate will cause carriers difficulty in the administration and setting of premium amounts as carriers will not be able to anticipate the assessment rate from year to year and cause instability in pricing these products.

IV. Assessment payment timeframe unreasonable for carriers

The Assessment Rule also sets forth of ten (10) business day window to pay the assessment. This time period is unreasonable and should be expanded to at least 30 days, which is the customary time frame for payment in most business transactions.

Thank you for consideration of our comments. Please do not hesitate to contact me at (949) 437-2750 or cmcelroy@metlife.com should you have any questions or concerns.

Sincerely,

Crystal C. McElroy
Assistant Vice President, Product Compliance and Regulatory
Group Dental and Vision Products
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America's Health Insurance Plans

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Washington, DC 20004

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www.ahip.org

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20005

Re: District of Columbia Health Benefits Exchange Funding Mechanism

Dear Ms. Kofman,

On behalf of America's Health Insurance Plans (AHIP), I am writing to comment on the Assessment Rule Informal Comment Discussion Draft (Discussion Draft) released on January 14, 2014, regarding a funding methodology to ensure the sustainability of the District of Columbia health benefits exchange, DC Health Link. AHIP is the national trade association representing the health insurance industry. AHIP's 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 also have demonstrated a strong commitment to participation in public programs.

The Discussion Draft proposes the creation of a new Subtitle D, Health Benefit Exchange, to be added to Title 26 of District of Columbia Municipal Regulations. This new subtitle would allow the DC Health Benefits Exchange Authority (Authority) to annually assess each health carrier doing business in the District a gross receipts tax in a percentage amount to be specified annually as necessary to support the operations of the Authority.

We understand from discussions with DC Health Link staff that the intention of this proposed

funding methodology is to include all entities that have over $50,000 in DC-based gross receipts per year, including major medical, Medicare Supplement, and other HIPAA excepted benefit products. We also understand that this assessment is to include the gross receipts of Medicaid managed care organizations (MCOs).

As articulated below, we have several concerns with this proposed funding methodology.

Undefined assessment amount creates instability. The Discussion Draft 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. We strongly object to an open-ended assessment amount for several reasons:

- An amount that varies each year is difficult to administer and creates unstable fluctuations in premium from year to year.
- 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 by the April/May deadline required by CMS for QHP and QDP filings.
- An open-ended assessment lacks sufficient incentives for the Authority to appropriately manage resources and meet specific budget targets.

HIPAA Excepted Benefits should not be included in the funding base. 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. 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.

In accordance with ACA requirements, DC Health Link limits the coverage it offers to qualified health plans (QHPs) and stand-alone dental plans that include essential pediatric benefits, referred to as qualified dental plans (QDPs). We recognize that the DC Health Link is required to be "financially self-sustaining" and suggest that the funding mechanism to achieve this should draw from stakeholders that either market their products on the exchange, or otherwise offer QHPs or QDPs, and only from premiums associated with QHPs or QDPs. We believe it inappropriate to include premiums for HIPAA excepted benefit products not offered through DC Health Link in any funding mechanism.

We would suggest that the Authority either limit the assessment to gross revenues from premiums associated with QHPs or QDPs, or consider the broadest funding base possible, such as general revenues. Doing so will ensure that purchasers of specific insurance products unrelated to the DC Health Link are not unfairly targeted.

Inclusion of Medicaid MCOs. We understand from discussions with DC Health Link staff that it is the intention to include Medicaid MCOs in the assessment base. As noted above, we believe it is inappropriate to include in the assessment base the premiums of products not offered through DC Health Link, including Medicaid MCOs. Should a decision be made to apply the assessment to Medicaid MCO premiums, it is important to note that federal law requires state Medicaid agencies to reimburse MCOs for the value of the assessment. 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." The American Academy of Actuaries has determined that actuarially sound rates for Medicaid MCOs are to include "any state-mandated assessments and taxes."[1] Therefore, if the DC Health Benefits Exchange chooses to apply the assessment to Medicaid MCOs, we request that there be a clear direction that the Department of Human Services must incorporate the assessment amount that will be levied into their budget so that it can be included in the capitation payments to MCOs.

Lack of 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 Authority may charge "user fees," "licensing fees" -- neither of which are proposed in the Discussion Draft -- and "other assessments," but it may do so only on "health carriers selling qualified dental plans or 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."

We request that the language describing the funding base be modified to specify that rather than assessing the gross revenues assessment on all health carriers, that this assessment be limited to "health benefit plans."

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

Transparency of assessment. We request that issuers be allowed to clearly indicate to consumers what portion of premium is attributable to the Exchange funding 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.

Assessment payment window. A 10-day payment window is unreasonable and should be expanded to at least 30 days, as is customary in most business transactions.

AHIP has serious concerns with the proposed assessment to fund the Exchange in its present form. We share your goal for a successful, financially sustainable health insurance market and

stand ready to work with the DC Health Link to find a solution that will ensure a robust marketplace. We appreciate your time and consideration of our comments and recommendations. 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,

Geralyn Trujillo, MPP
Regional Director

cc: Kevin Wrege

From: Cohan, Colleen C [mailto:colleen_cohan@uhc.com]
Sent: Wednesday, January 29, 2014 1:30 PM
To: Assess
Subject: UnitedHealthcare Feedback on DC HBX Authority Assessment Rule

Good afternoon,

Thank you for the opportunity to comment on the District of Columbia Health Benefit Exchange Authority's Assessment Rule Informal Comment Discussion draft. UnitedHealthcare appreciates the opportunity to review and share our comments and recommendations.

As we noted in our earlier comments on the "Report to the Mayor and Council of the District of Columbia on Financial Sustainability from the District of Columbia Health Benefit Exchange Authority"

(the Draft Financial Sustainability Report), 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. However, 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 fee. We suggest that the broad-based fee be limited to a period of two years and then re-evaluated to determine if, based on the costs to operate the Exchange and the total membership, a user-based fee is feasible. Additionally, we encourage the Authority to leverage Medicaid Federal matching dollars to the extent the Exchange handles Medicaid/CHIP administrative functions and/or authorizes Navigators to assist with enrollment into those programs. 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.

Regarding assessment calculation, we urge 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, as proposed in the regulation. Doing so will be more reflective of Carriers' current business volumes and result in a more equitable assessment across Carriers. We recommend this monthly assessment be communicated to carriers well in advance, using a prospective adjustment to avoid a year end true-up and allow such costs to be reflected in future premiums. For example, for 2015 carriers would need to know the amount of the per member per month fee by the end of the first quarter of 2014. However, should the Authority move forward with an annual assessment, we recommend that Carriers be allowed at minimum 30 calendar days to pay the assessment rather than the ten business day deadline noted in the proposed rule.

Additionally, 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.

Colleen C. Cohan
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From: Kathryn Ray and Dennis Beaufort [mailto:kcrdlb@gmail.com]
Sent: Saturday, January 18, 2014 8:00 AM
To: Assess
Subject: HBX Proposed Assessment Rule

I am a private citizen with no ties to the insurance industry. I believe that a requirement for payment within 10 days is unreasonable.

A business needs to know how much the assessment will be well in advance of a demand for payment.

Sincerely,

Kathryn Ray

From: Christopher Avery [mailto:caverymac@mac.com]
Sent: Friday, January 17, 2014 8:19 AM
To: Assess
Subject: Health Assessments

Hi -

This document is much to brief to make any kind of judgement. First, it needs to explain why the agency is needed and what it is intended to accomplish. Secondly, it needs to address whether any other means of funding were considered. Finally, it needs to address the effects of this assessment might have on the health carriers.

Then one could make an intelligent comment.

Best -

Christopher Avery

caverymac@mac.com