



January 27, 2022

*Submitted via [www.regulations.gov](http://www.regulations.gov)*

Centers for Medicare & Medicaid Services  
Department of Health and Human Services,  
Attention: CMS-9911-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 -- CMS-9911-P**

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments in support of the proposed rule.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

HBX supports CMS's policies that provide flexibility for state-based marketplaces (SBMs), allowing states to design programs that best serve the needs of their consumers and allow for state innovation. HBX also applauds and strongly supports CMS for its strong commitment to equity and nondiscrimination. HBX strongly supports CMS's proposal to explicitly reinstate nondiscrimination protections based on sexual orientation and gender identity, reduce health disparities, strengthen consumer protections including guaranteed availability, remove barriers for enrollment using special enrollment periods, and additional safeguards to prevent discriminatory benefit design. These proposals are essential to ensuring that consumers can access high quality coverage that meets their needs, which is critical as we continue to navigate through a global pandemic.

HBX has concerns about some proposed approaches that would inadvertently curtail state health equity initiatives, or require significant investments by SBMs in IT or staffing. The proposed actuarial value standards and essential health benefits would inadvertently hinder state efforts to address health disparities. In addition, the proposal to create a new audit by CMS of SBMs



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would create severe and unnecessary resource burdens on SBMs such as HBX, especially during a time when SBMs should be ensuring access to affordable, quality health insurance, and working to reduce health disparities.

Part I below includes areas that we would like CMS to reconsider, including one proposed area that we oppose. Part II includes CMS's proposed changes we generally support and ask for additional clarification. Part III includes areas that we support, applaud CMS for initiating, and urge adoption.

## **Part I**

### **Refine EHB Nondiscrimination Policy for Health Plan Design (§ 156.125)**

CMS proposes defining nondiscriminatory EHB benefit design to be one that “is clinically-based, incorporates evidence-based guidelines into coverage and programmatic decisions, and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources.”<sup>1</sup> While we applaud CMS's efforts to end discriminatory plan design, unfortunately, the proposed new standard could have the exact opposite effect. Instead of prohibiting discrimination, the proposed standard may perpetuate systemic racism and biases in health care.

CMS's proposed standard could perpetuate systemic racism and biases because the standard relies on the currently imbedded systemic racism and biases in medical professional and research structures. Women and communities of color are underrepresented and have even been excluded in research structures, such as grants, publications, and clinical trials. Despite active efforts to thwart the historical discrimination, studies show that institutional systemic discrimination persists. For example, the National Institutes of Health (NIH) Revitalization Act of 1993 (Act) requires NIH-funded clinical trials to include women and minorities as participants and assess outcomes by sex and race or ethnicity to address historical biases. To gauge effectiveness of that law and other efforts, researchers reviewed the 142 randomized clinical trials funded by NIH and reported in 14 leading U.S. medical journals published in 2015.<sup>2</sup>

More than two decades since the passage of the Act, of the 142 studies:

- 77 studies did not mention whether sex was included in their analyses, did not report sex-specific outcomes, or provide explanations as to why not;
- 107 studies included both men and women and of those, 16 studies enrolled less than 30% women, with 7 studies having less than 15% women in the study population, 4 studies did not even report the number of male versus female subjects or offer reasons for not reporting. Only in a quarter of the studies with female enrollment below 30% did the

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<sup>1</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584, 726 (Jan. 5, 2022).

<sup>2</sup> See Geller, Koch, Roesch, Filut, Hallgren, Carnes, “The More Things Change, the More They Stay the Same: A Study to Evaluate Compliance With Inclusion and Assessment of Women and Minorities in Randomized Controlled Trials” Acad. Med. (April 2018), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5908758/>.

authors take the proactive step of noting that their findings may not be generalizable to women;

- Only 7 studies reported primary study outcomes by race/ethnicity, and only 19 either reported outcomes by race and/or ethnicity or included it in their analyses; and
- Hispanic enrollment was not reported in over half the studies.<sup>3</sup>

Similarly, despite multiple efforts led by the federal government, minority and female patients remain underrepresented in cancer clinical trials.<sup>4</sup> For example, Black Americans make up more than 13% of the U.S. population. But in the clinical trials that led to FDA approval of four new breast cancer treatments in 2020, only 2% to 9% of participants were African American.<sup>5</sup> Similarly, Hispanic or Latin Americans make up 18.5% of the U.S. population but accounted for 0% to 9% of participants in those same trials.<sup>6</sup>

According to researchers, the biases in clinical trials have severe outcomes with women having greater adverse drug reactions, gender bias in use of medical devices, and with regard to race and ethnicity, “variations in drug metabolism and toxicity in chemotherapy, antiretroviral agents, immunosuppressant drugs, and cardiovascular medications.”<sup>7</sup> Even widely used practices such as taking a low-dose aspirin for primary prevention of heart disease have recently been found to not be effective in reducing the risk of fatal heart attacks in African Americans as it is in the White population.<sup>8</sup> Original studies that supported the effectiveness of low-dose aspirin mostly excluded African Americans, despite African Americans having a higher risk of a heart attack, stroke or other heart diseases compared to whites.<sup>9</sup> In the more recent study that found African Americans do not gain heart benefits from low-dose aspirin, two-thirds of the participants were African Americans.<sup>10</sup>

Furthermore, biases exist in medical professional organization guidance. For example, the American Heart Association’s Get with the Guidelines-Heart Failure tool adds 3 points to the risk score if the patient is not African American, which could increase the threshold for African

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<sup>3</sup> See *id.*

<sup>4</sup> “Of 1,012 clinical trials [from 2003 to 2016], 310 (31%) reported ethnicity with a total of 55,689 enrollees. Participation varied significantly across ethnic groups. Non-Hispanic whites were more likely to be enrolled in clinical trials (EF, 1.2%) than African Americans (EF, 0.7%;  $P < .001$ ) and Hispanics (EF, 0.4%;  $P < .001$ ). A decrease in African American (6% v 9.2%) and Hispanic (2.6% v 3.1%) enrollment was observed when compared with historical data from 1996 to 2002.” See Duma, Aguilera, Paludo, Haddox, Velez, Wang, Leventakos, Hubbard, Mansfield, Go, Adjei, “Representation of Minorities and Women in Oncology Clinical Trials: Review of the Past 14 Years” *Journal of Oncology Practice* (Jan. 2018), available at <https://ascopubs.org/doi/abs/10.1200/JOP.2017.025288>.

<sup>5</sup> See DePolo, “Racial, Ethnic Minorities Underrepresented in Cancer Research,” *BreastCancer.org* (Nov. 2021), available at <https://www.breastcancer.org/research-news/minorities-underrepresented-in-cancer-research>.

<sup>6</sup> See *id.*

<sup>7</sup> “Sex differences are observed in response to many drugs. Females have a 1.5–1.7-fold greater risk of developing an adverse drug reaction, and several drugs have been withdrawn from the market over the last two decades because of sex-based adverse events.” See Coakley, Fadiran, Parrish, Griffith, Weiss, Carter, “Dialogues on Diversifying Clinical Trials: Successful Strategies for Engaging Women and Minorities in Clinical Trials,” *Journal of Women's Health* (Jul. 2012), available at <http://doi.org/10.1089/jwh.2012.3733>.

<sup>8</sup> See Mundell, “Black Patients May Not Gain Heart Benefit From Low-Dose Aspirin” *WebMd* (Dec. 2019), available at <https://www.webmd.com/heart-disease/news/20191211/black-patients-may-not-benefit-on-low-dose-aspirin>.

<sup>9</sup> See *id.*

<sup>10</sup> See *id.*

Americans accessing care.<sup>11</sup> The Society of Thoracic Surgeons Short Term Risk Calculator risk score for operative mortality and major complications increases up to 20% for African Americans.<sup>12</sup> When this risk calculator is used, it could limit access to necessary surgeries for some patients.

Additionally, efforts to address bias in clinical guidelines are slow. After approximately two decades in use, in September 2021 the American Kidney Foundation (AKF) updated its recommendations on use of race adjustment in estimating glomerular filtration rate (GFR). GFR measures kidney function. Race adjustment created a higher score for African Americans making it look like kidneys were functioning better than they were, which resulted in delayed placement on kidney transplant lists and delayed care.<sup>13</sup> We applaud AKF for updating the GFR guidance and note that other medical bodies have yet to update their guidance.

As part of our health equity work, HBX partnered with health plans to identify and address bias in clinical decision-making tools.<sup>14</sup> We encourage CMS to consider similar initiatives to identify and address bias in generally accepted sources of information and clinical tools.

Additionally, systemic discrimination persists in who gets research funding, which in turn perpetuates bias. A review in 2011 and again in 2019 found that over a 7-year period, applications for independent research grants from white Principal Investigators (PIs) were 1.7 times more likely to be funded than applications from African-American PIs.<sup>15</sup>

Even with current social justice initiatives, it is unclear when we will remediate historical institutionalized racial and gender discrimination and bias that continues today.

While HBX generally supports a proposal to guard against arbitrary or discriminatory plan design, we encourage CMS to consider additional safeguards against reliance on studies or clinical guidelines that are biased due to the exclusion of historically disadvantaged communities.

By requiring plan design to be based on clinical or medical guidelines, CMS is inadvertently further perpetuating and imbedding existing systemic discrimination and biases into health plan design. And if there isn't a clinical basis found through clinical trials, evidence-based

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<sup>11</sup> See American Heart Association's Get With The Guidelines-Heart Failure Risk Score *available at* <https://www.mdcalc.com/gwtg-heart-failure-risk-score>; Vyas, Eisenstein, Jones, "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms," *N Engl J Med* (Aug. 2020), *available at* <https://www.nejm.org/doi/full/10.1056/NEJMms2004740>.

<sup>12</sup> See Vyas, Eisenstein, Jones, "Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms," *N Engl J Med* (Aug. 2020), *available at* <https://www.nejm.org/doi/full/10.1056/NEJMms2004740>.

<sup>13</sup> See "NFK and ASK Release New Way to Diagnose Kidney Diseases," National Kidney Foundation, (Sept. 2021), *available at* <https://www.kidney.org/news/nkf-and-asn-release-new-way-to-diagnose-kidney-diseases>.

<sup>14</sup> See DC Health Benefit Exchange Authority Executive Board Resolution, "To adopt the consensus recommendations of the Social Justice and Health Disparities Working Group to advance equity and reduce health disparities in health insurance coverage for communities of color," (July 2021), *available at* <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20on%20Social%20Justice%20%20Health%20Disparities%20Working%20Group%20Recommendations.pdf%20FINAL.pdf>.

<sup>15</sup> See Taffe, Gilpin, "Racial inequity in grant funding from the US National Institutes of Health," *eLife* (Jan. 2021), *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7840175/>.

guidelines, peer reviewed medical journals, etc. because a group, e.g. trans-gender people, are excluded from medical research, does that mean that issuers can limit covering certain services?

In addition to the above concerns, CMS's nondiscrimination efforts could limit state actions to improve health equity. We are concerned that the new proposed standard will limit our plan design work to address health disparities. The HBX Executive Board established a Social Justice and Health Disparities Working Group. The working group was comprised of diverse stakeholders committed to social justice and health equity, including all of the issuers offering coverage on DC Health Link, patient advocates, health equity experts, members from our broker community, providers, including doctors and hospitals. Among unanimous recommendations the Working Group proposed and in July 2021 the Executive Board adopted was to modify plan design for the DC Health Link standard plans to eliminate cost-sharing for conditions that disproportionately affect patients of color in the District. We prioritized the following conditions:

- (1) for the adult population-- diabetes, cardiovascular disease, cerebrovascular disease, mental health, and HIV, as well as cancer of the breast, prostate, colorectal and lung/bronchus; and
- (2) for pediatric population-- mental and behavioral health services.<sup>16</sup>

HBX's Stakeholder Standard Plan Working Group updated the standard plan design for plan year 2023 focusing on type 2 diabetes coverage. In the District of Columbia 14% of African-American adults and 8% of Hispanic adults had diabetes compared to 2% of White adults.<sup>17</sup> Based on the Standard Plan Working Group's unanimous recommendations and subsequent Executive Board adoption,<sup>18</sup> Standard Plans will cover medical care for diabetes including physician visits, blood tests, vision and foot exams, prescription medications, and supplies with no cost-sharing – no deductibles, no copays, and no coinsurance. Using coverage design is one important way HBX can help address health disparities -- by eliminating cost-sharing we eliminate a financial barrier to medical care for diabetes, a condition that disproportionality impacts communities of color in the District. And already in 2022, our individual market standard plans have zero cost-sharing for insulin and diabetic supplies. HBX will expand no cost-sharing coverage design to include additional conditions in future years.<sup>19</sup>

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<sup>16</sup> See DC Health Benefit Exchange Authority Executive Board Resolution, "To adopt the consensus recommendations of the Social Justice and Health Disparities Working Group to advance equity and reduce health disparities in health insurance coverage for communities of color," (July 2021), available at <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20on%20Social%20Justice%20%20Health%20Disparities%20Working%20Group%20Recommendations.pdf%20FINAL.pdf>.

<sup>17</sup> District of Columbia data for Non-Hispanic African Americans and Whites from 2020 and Hispanics from 2018. See United Health Foundation, *America's Health Rankings*, available at <https://www.americashealthrankings.org/explore/annual/measure/Diabetes/state/DC>.

<sup>18</sup> See DC Health Benefit Exchange Authority Executive Board Resolution, "To implement and adopt recommendations from the Social Justice and Health Disparities Working Group: Modify insurance design for DC Health Link standard plans to eliminate cost-sharing, including deductibles, co-insurance, and co-payment, for medical care, prescription drugs, supplies and related services that prevent and manage diseases and health conditions that disproportionately affect patients of color in the District," (July 2021), available at [https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page\\_content/attachments/Resolution%20Std%20Plan%20Social%20Justice%20Recommendation%2011%2010%2021%20FINAL.pdf](https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/Resolution%20Std%20Plan%20Social%20Justice%20Recommendation%2011%2010%2021%20FINAL.pdf).

<sup>19</sup> See DC Health Benefit Exchange Authority Executive Board Resolution, "To adopt the consensus recommendations of the Social Justice and Health Disparities Working Group to advance equity and reduce health disparities in health insurance coverage for communities of color," (July 2021), available at

It is not clear whether the proposed non-discrimination standard allows plan design that eliminates cost-sharing for conditions that disproportionately impact communities of color or other disadvantaged populations.

We ask that CMS ensure efforts reasonably designed as part of a SBM or other state efforts to improve health equity are permitted under EHB nondiscrimination requirements.

We also ask CMS to consider the unintended consequences of the proposed non-discrimination standard.

### **Levels of Coverage (Actuarial Value) (§ 156.140, 156.200, 156.400)**

CMS is proposing changes to de minimis ranges and makes additional changes to the AV calculator in the Draft 2023 Actuarial Value Calculator.<sup>20</sup> We request additional flexibility for SBMs using plan design to address health disparities. Specifically, we would like CMS to allow a higher de minimus range for Gold to allow +3 and for Silver to allow +4. Allowing +3 and +4 variations would be consistent with the already allowed de minimis range of +5 for Bronze. CMS could also limit this greater variation to standard plan design that promotes health equity.

As part of our health equity initiatives, we are in the process of implementing equity focused value-based insurance designs in our standard plans. As we discussed in section on EHB nondiscrimination, Plan Year 2023 Standard Plans will cover medical care for diabetes including physician visits, blood tests, vision and foot exams, prescription medications, and supplies with no cost-sharing – no deductibles, no copays, and no co-insurance. We expect to move forward with similar treatment of other chronic health conditions that disproportionately affect communities of color in DC, including pediatric behavioral and mental health, HIV, cardiovascular disease, and several types of cancer, including breast and lung.

Our actuaries ran our current 2022 standard plans, plus the diabetes \$0 cost-sharing described above, through the draft 2023 calculator. The results are concerning and pose very real challenges for our ongoing equity work:

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<https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20on%20Social%20Justice%20%20Health%20Disparities%20Working%20Group%20Recommendations.pdf%20FINAL.pdf>.

<sup>20</sup> CMS, “Draft 2023 Actuarial Value Calculator Methodology” (Dec. 30, 2021), *available at*

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2023-AV-Calculator-Methodology.pdf>.

Marketplace QHP AV

<b>Metal Level - AV</b>	<b>Allowed Range for 2022</b>	<b>Base for 2022</b>	<b>+ \$0 Diabetes</b>	<b>Proposed Allowed Range for 2023</b>	<b>Base for 2023 (run against proposed AV calculator)</b>	<b>+ \$0 Diabetes</b>
Platinum – 90%	+2/-4	88.99%	89.04%	+2/-2	89.85%	89.89%
Gold – 80%	+2/-4	81.95%	81.98%	+2/-2	82.92%	82.96%
Silver – 70%	+2/-4	71.95%	71.99%	+2/0	73.72%	73.76%
Bronze – 60%	+5/-4	64.95%	64.99%	+5/-2	64.84%	64.88%

Our standard gold and silver plans will require substantial increases in cost-sharing to consumers to get them within the proposed 2023 allowable range. Note that eliminating cost-sharing for diabetes care only adds .03-.05 to AV. However, the proposed 2023 AV would necessitate dramatic changes to our standard plan design and would make it nearly impossible to use plan design to address health disparities.

Furthermore, the only way to comply with the CMS proposed 2023 AV changes would be to increase out-of-pocket costs dramatically for enrollees in standard plans. Our standard plans cover physician visits, specialist visits including mental health and behavioral health, urgent care and generic Rx without deductibles. And there are no limits on how many times you can see your doctors. This standard plan design means that everyone has access to essential care without the financial burden of a high deductible. Access to essential care without deductibles is how we eliminate financial barriers to care and ensure that residents can access essential care. Also, only 3.02% of our individual market enrollees (2.79% in 2020) qualify for cost-sharing reductions. Increasing cost-sharing is likely to result in some residents delaying or foregoing care, or even dropping their insurance because of higher out-of-pocket costs and less value. In the alternative, not covering benefits pre-deductible – pre-deductible essential care makes coverage very valuable to many enrollees -- is likely to result in some residents dropping their insurance. For us, further increasing out-of-pocket costs in standard plans is not a viable option especially because of the unintended effect of causing some people to drop their coverage, becoming uninsured.

Additionally, even if we shifted costs to patients by having higher out-of-pocket costs, the proposed 2023 AV calculator would foreclose our ability to add conditions disproportionately impacting communities of color for coverage at zero-dollar cost-sharing. CMS's proposed AV calculator changes have an unintended impact of halting our efforts to use plan design to address health disparities.

President Biden's Executive Order calls on the entire government to act to address disparities. It states:

Entrenched disparities in our laws and public policies, and in our public and private institutions, have often denied that equal opportunity to individuals and communities. Our country faces converging economic, health, and climate crises that have exposed and exacerbated inequities, while a historic movement for justice has highlighted the unbearable human costs of systemic racism. Our Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face.<sup>21</sup>

By accepting our recommended approach, allowing for a +3 de minimis variation for Gold and a +4 de minimis variation for Silver, CMS would promote the Administration's goal of eliminating health inequities and using the whole-of-government to do so. Importantly, it will allow us and other SBMs to use coverage design as an important way to address health disparities.

### **State Exchange Improper Payment Measurement (§155.1500 et seq.)**

HBX strongly opposes the proposal to create the State Exchange Improper Payment Measurement (SEIPM) program. The proposed federal audit duplicates existing audits and creates significant new financial, system, and resource burdens on SBMs such as HBX. Existing federal and local audit requirements already satisfy the oversight requirements of the Payment Integrity Information Act of 2019 (PIIA) and the proposed new audit is duplicative.

#### *Existing Oversight Measures Meet PIIA Goals*

CMS indicates that it must implement the SEIPM program to comply with the PIIA. However, CMS does not provide evidence as to why its existing oversight activities can't be used to conduct the improper payment risk assessment, improper payment estimates, and corrective action plan reporting required by the PIIA. In fact, the proposed rule acknowledges that CMS already monitors eligibility and enrollment errors and payment discrepancies through activities that include:<sup>22</sup>

- An annual report showing compliance with federal requirements, which includes completion of a programmatic audit by an independent auditor at the exchange's expense;
- Monthly payment dispute reconciliation;

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<sup>21</sup> See Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, No. 13985, Jan. 20, 2021. 86 Fed. Reg. 7009 (Jan. 25, 2021).

<sup>22</sup> See 87 Fed. Reg. at 654.



- An annual report on instances in which the State Exchange did not reduce an enrollee’s premium by the amount of the APTC in accordance with §155.340(g)(1); and
- Quarterly submission of performance monitoring data.

Given this extensive and frequent oversight framework, adding the SEIPM program to current oversight activities is redundant and unnecessarily burdensome. In particular, the following oversight activities already target eligibility and enrollment errors or improper payments:

- Annual Programmatic Audits – 45 C.F.R. §155.1200(c) requires that an exchange hire an independent auditor to conduct an annual programmatic audit. While HBX agrees with the proposal at §155.1200(e) that an exchange should not be required to engage in both the audit under §155.1200(c) and the SEIPM, CMS does not provide a reasonable rationale indicating that the SEIPM is a necessary replacement.

CMS’s rationale for why it would not simply update its auditing guidelines for independent auditors is falsely premised. First, CMS acknowledges in the proposed rule that this audit, along with the corrective action plans that CMS monitors closely, “allows HHS to oversee compliance with eligibility and enrollment standards to ensure that State Exchanges are conducting accurate eligibility determinations and enrollment transactions.”<sup>23</sup> The independent auditors conduct these audits pursuant to CMS guidelines while allowing for necessary adjustments to ensure they are collecting the right data. Contrary to CMS’s assertion that using different “third-party reviewers” to make improper payment estimates would undermine the utility of the results,<sup>24</sup> meaningful review must allow auditors to adjust for each marketplace’s unique eligibility and enrollment system architecture and market conditions. Such adjustments are crucial to ensuring the audit results are accurate. For example, in 2021, only 16% of HBX’s individual market enrollees received APTC. Recognizing this, our independent auditor created separate samples that test enrollment eligibility generally as compared to APTC eligibility specifically. Second, CMS has said that engaging “third-party reviewers” to estimate improper payments would place an additional burden on CMS and the SBMs because “the third party would need to obtain personally identifiable information from both state and federal data systems.”<sup>25</sup> However, for the current programmatic audits, the independent auditors already receive extensive PII as well as the information returned from federal data services that were used to verify eligibility; this is not an additional burden. Additionally, the independent auditors already make findings as to eligibility and enrollment errors. Receiving data on the amount of APTC associated with all enrollments (including those containing errors), current independent auditors could easily formulate improper payment estimates.

- Monthly Payment Dispute Reconciliation – On a monthly basis, CMS sends data files to exchanges to reconcile discrepancies between the APTC amounts issuers are claiming and the amounts reported to CMS by SBMs. Although HBX’s experience indicates there

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<sup>23</sup> 87 Fed. Reg. at 654.

<sup>24</sup> 87 Fed. Reg. at 718.

<sup>25</sup> 87 Fed. Reg. at 718.

are infrequent and easily explained discrepancies, these monthly engagements between CMS and HBX allows HBX to promptly make necessary corrections by updating the reporting in the next month's SBMI file and to address any systematic issues that may be creating the discrepancies. This is one of many ways CMS now has to assess improper payment risk and to estimate amounts of improper payments.

### *SEIPM Proposal Unworkable and Burdensome*

While the entire program is problematic and unnecessary, the following elements of the proposed regulations at §155.1500 *et seq.* are particularly concerning because they create significant new burdens for SBMs:

- Ambiguous, Burdensome, or Unnecessary Data Requests – The proposed rule does not provide clear standards for what exchange data will satisfy the SEIPM audit. This fact creates ambiguity as to how to respond to the proposed rule with full specificity. Although HBX hopes this lack of clarity indicates that CMS will allow exchanges flexibility in implementation, reading the proposed rule as a whole suggests an intent to request the same data of all SBMs in a standardized format. However, in circumstances where self-attestation is accepted, exchanges may not have the requested data available. If CMS requires data currently not collected, we will have to invest staff and financial resources to collect new data. In some cases, it won't be possible to find formerly enrolled customers who are no longer enrolled. The proposed audit is unnecessary and will create a poor customer experience.

In other areas, and as described above, CMS already has access to much of the data that exchanges would have to report under the proposed new audit scheme. Exchanges already report enrollment and disenrollment data monthly, including retroactive corrections. Additionally, the primary verification sources are housed in the Federal Data Services Hub (FDSH), to which CMS has access. Requiring exchanges to provide this same data would be duplicative and could create the appearance of a discrepancy where there is no discrepancy.

- Standardized Requests – The proposed rule indicates CMS will create a “data request form” to compile eligibility and enrollment data from each exchange. HBX is concerned CMS would create its standardized requests based on an improper presumption that SBMs collect and organize their data in a format similar to the federal exchange's. However, the ACA provides SBMs flexibility on design of eligibility and enrollment systems and data storage. As noted above, the independent auditors that work with each state on the annual programmatic audit recognize this and formulate their audit plan to ensure the necessary information is collected consistent with generally accepted government auditing standards (GAGAS) and CMS guidance. A new reporting scheme would require SBMs to invest funding into changing their IT system data storage and/or hiring additional resources to generate and submit the data in new required format (also requiring expensive IT resources to generate the data).

If the SEIPM program were implemented, and even if it recognized the differences between the FFM and SBMs and among SBMs, substantial education of the federal auditors would be required before they could begin their audit and ongoing education would be required to prevent misinterpretation of the data. Conducting this education unnecessarily replicates the work done with independent auditors by SBMs and places new substantial burdens on the SBMs. This is not a theoretical problem. It is our understanding from the experience of another SBM participating in the pilot of the EIPM program that the process, which is ongoing since 2016, is complex and resource-intensive, involving extensive engagement of staff from operations, IT, policy, and legal teams. The process has been more difficult than the annual programmatic audit because CMS is attempting to create a standardized approach across Exchanges, often based on the data model and procedures used by the federally facilitated Exchange (FFE) that do not comport with SBM practices, despite the significant flexibility offered to states in the SBM model more generally under the Affordable Care Act. In addition to outlining and documenting its own detailed procedures, the SBM has had to map them against the standardized approach in CMS documents, which has resulted in a number of questions and iterative dialogue with CMS about what is being requested, diverting staff attention and resources from day-to-day operations and responsibilities. HBX does not have resources to have audits that last for years and cannot divert staff attention to multi-year audits. Being funded through an assessment on health issuers, every dollar increase in assessment gets shifted to enrollees in higher premiums. And, nearly all of our enrollees are full pay – 16% are APTC recipients in 2021 and prior to the American Rescue Plan (ARP) only 8% received APTC. There are no federal dollars subsidizing or absorbing the higher assessments that this new federal audit scheme would require.

- Regimented Error Redeterminations & Appeals – CMS proposes a difficult and regimented process for having error findings redetermined by the auditor and, if necessary, reversed on appeal by CMS. This framework is improper if the goal is to produce accurate findings that are informative to the exchange and accurate for the improper payment estimation process. As written, the auditor may only consider an exchange’s initial data submission and may in fact make an erroneous finding. The auditor is free to make findings without following up with the exchange for clarifications that may negate the need for an erroneous finding.<sup>26</sup> While HBX understands CMS’s desire to prevent incomplete submissions, the best approach is a collaborative one between the auditor and the exchange. As the auditor starts to focus in on what it believes may be errors, the exchange should be able to provide new information on those cases in an effort to prevent erroneous findings. In fact, in all federal and local audits that we are subject to, auditors provide us with an opportunity to discuss the validity of the potential finding(s) and provide evidence that: 1) Changes the finding, 2) Eliminates the finding because it was erroneous, or 3) Maintains the finding with management response. The proposed CMS process creates a “gotcha” scheme not designed for meaningful discovery of problems and workable solutions to address those problems. The proposed scheme is contrary to all prior CMS oversight proposals and work with SBMs.

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<sup>26</sup> 87 Fed. Reg. at 657-658 (indicating accepting new information would be discretionary).

In addition, this new burdensome audit is reminiscent of the early days when SBMs opened. Back then we had local Comprehensive Annual Financial Report audit (we still have annually), Single-Audit (for federal grants), HHS Office of Inspector General audit, HHS Office of Inspector General Cost Allocation audit, Insurance Regulatory Trust Fund Bureau audit (used to be annually, now biennial), CMS SMART audit (annual), CMS Privacy Impact Assessment (triennial), IRS Federal Tax Information audit (periodic), IRS Safeguard Security Report (periodic), Inspector General For Tax Administration (periodic), GAO audits (periodic), GAO Special Enrollment Period audit, GAO IT audit, and other federal and local one-time, periodic, and annual audits. Requiring new duplicative, burdensome and resource intensive audits is one way to deplete and divert limited resources from enrollment and support for customers.

For all these reasons, HBX opposes the proposed SEIPM program scheme contained in this proposed rule. We ask CMS to reject this proposal in its entirety as unworkable, unnecessary, and overly burdensome. If new audit scheme is necessary, then we urge CMS to convene a CMS and SBM working group to identify specific areas that CMS wishes to address through audits and workable audit approaches for areas.

## **Part II**

### **Employer-sponsored Plan Verification (§ 155.320)**

HBX supports the proposal to allow SBMs to tailor their employer-sponsored insurance (ESI) verification process, including allowing self-attestation if the risk of improper APTC/CSR payments is low. HBX's experience with random sampling was similar to that of the federal exchange; it was resource-intensive and the burden associated with the verification activity far outweighed the activity's value to program integrity.<sup>27</sup> This result is consistent with general expectations as to consumer behavior; it is simpler for individuals with access to ESI to enroll in that coverage and they can pay their portion of the premiums pre-tax. Additionally, the employer premium contribution may often exceed the amount of APTC a person or family could receive, thus making the ESI more affordable than exchange coverage. All of these factors indicate a low risk of improper APTC/CSR payments. HHS's study came to the same conclusion, finding "that there is likely a very low volume of applicants with offers of affordable coverage through their employer that choose to inappropriately enroll in an Exchange QHP with APTC and CSRs."<sup>28</sup>

To implement this proposal, HBX suggests that the revision to (d)(4)(i) specifically state that the verification plan implemented by an exchange can utilize self-attestation. This is the method the federal marketplace intends to use<sup>29</sup> and CMS should be clear in regulation that it is a permissible approach for SBMs.

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<sup>27</sup> 87 Fed. Reg. at 649.

<sup>28</sup> 87 Fed. Reg. at 649.

<sup>29</sup> 87 Fed. Reg. at 650.

**Special Enrollment Periods—Special Enrollment Period Verification (§ 155.420)**

HBX supports CMS’s proposal, which affirms that SBMs are not required to conduct pre-enrollment verification for special enrollment periods (SEPs).<sup>30</sup> This aligns with current federal law.

Importantly, based on the CMS data on disproportionate negative impact on African Americans and Black Americans and on younger consumers,<sup>31</sup> we request that CMS prohibit pre-enrollment verifications unless an SBM can show that in that state, there is not a disproportionate impact on communities of color. Although pre-enrollment verifications policy is rooted in an effort to find fraud and misrepresentation, there are other ways including post-enrollment audits to accomplish that goal. There is no public policy that supports on-going pre-enrollment verifications that lead to communities of color being shut out of affordable quality health insurance through ACA exchanges.

CMS previously justified pre-verification requirements based on the unsupported assertion that SEPs were being abused by enrollees resulting in adverse selection. CMS did not provide data supporting abuse of SEPs. CMS also failed to provide data supporting the assertion that abuse of SEPs resulted in adverse selection.

HBX consistently monitors SEP enrollment patterns and we have not seen evidence of abuse. We also coordinate closely with our issuers, who have not reported patterns of abuse. In fact, in reviewing 2019-2021 enrollment, the age of the SEP population remained consistent with the population that enrolled during open enrollment, and in some cases was even younger. Age is a proxy for health care usage.

Age	2019 Open Enrollment %	2019 SEP %	2020 Open Enrollment %	2020 SEP %	2021 Open Enrollment %	2021 SEP %
< 18	10%	10%	10%	10%	9%	10%
18-25	5%	7%	10%	9%	10%	9%
26-34	34%	40%	39%	44%	42%	44%
35-44	22%	22%	20%	18%	19%	19%
45-54	15%	12%	11%	10%	11%	9%
55-64	13%	9%	9%	8%	8%	8%
65+	1%	1%	1%	1%	1%	1%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

HBX also learned from our experience with SEP verification when we first deployed the on-line marketplace in 2013 and 2014. At that time, we required documentation and manually processed all SEPs. The documentation verifications yielded nearly no positive results and created huge backlogs, delaying people’s coverage.

<sup>30</sup> 87 Fed. Reg. at 723(to be codified at 45 C.F.R. § 155.420(g)).

<sup>31</sup> 87 Fed. Reg. at 653.

Accepting self-attestation aligns with other federal programs that have long allowed self-attestation, recognizing that consumers generally do not lie under penalty of perjury. For example, the Internal Revenue Service relies on tax filers to self-attest to income and deductions and does not receive verification forms from third parties for all income sources and deductions, particularly for several categories of itemized deductions<sup>32</sup> or self-employment income/deductions. Similarly, when administering the federal student loan program, the U.S. Department of Education expects educational institutions to verify information on the Free Application for Federal Student Aid forms for only those forms specifically selected for verification by the Secretary or the institution itself.<sup>33</sup> Notably, if the applicant was determined eligible to receive only unsubsidized student financial assistance, his/her form is specifically excluded from verification.<sup>34</sup>

For these reasons, we support CMS's proposed approach on pre-enrollment verifications. HBX also appreciates the preamble language on state flexibility and that CMS recognizes the importance of marketplaces reflecting the needs of their consumers and market. However, state flexibility should never go below the federal floor of protections. And in this case, we request that CMS prohibit pre-enrollment verifications unless an SBM can show that, in that state, there is not a disproportionate impact on communities of color.

### **Standardized Options (§ 156.201)**

CMS proposes to require FFE and SBE-FP issuers to offer plans with standardized cost-sharing parameters at every product network type, metal level, and throughout every service area that they offer non-standardized options. We support a standardized plan design and encourage CMS to consider changes that will improve access to essential care.

The proposed bronze plan has a \$9,100 annual deductible and except for preventive care benefits does not provide any services pre-deductible. This means that enrollees are uninsured for part of the year. For people who can't afford medical care, this means delaying or foregoing necessary care and treatments. The proposed plan design is contrary to the ACA's goal of providing affordable care to people. Even catastrophic plans cover three primary care visits without a deductible.

DC Health Link standard plans cover certain essential health care without deductibles. Our standard plans cover physician visits, specialist visits including mental health and behavioral health, urgent care and generic Rx without deductibles. Access to care without deductibles is how we eliminate financial barriers to care and ensure that residents can access essential care.

We encourage CMS to revisit bronze plan design. The federal government should be encouraging enrollment in plans that provide value – through access to medical care. Absent changes to the proposed plan design, some consumers will wrongly believe that the new standard

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<sup>32</sup> See IRS Form 1040, Schedule A; see e.g. 26 C.F.R. 1.170-1 (charitable deductions); 26 C.F.R. §1.212-1(g) (investment advisory fees); 26 C.F.R. § 1.212-1(h) (rental property expenses); 26 C.F.R. §1.212-1(l) (tax form preparation fees); 26 C.F.R. §1.213-1 (medical and dental expenses).

<sup>33</sup> 34 C.F.R. § 668.54(a).

<sup>34</sup> 34 C.F.R. § 668.54(b).

bronze plans provide them with financial and health security. If CMS cannot change benefit design because of AV limitations, we encourage CMS to get rid of this design altogether. Consumers who can't afford a regular bronze plan – what CMS calls “Expanded Bronze” – can enroll in a catastrophic plan, which is a better value than proposed bronze plan. To make enrollment easier, CMS could add an automated enrollment feature to HealthCare.gov that accepts attestation on affordability and qualification for catastrophic plans.

Furthermore, the proposed plan designs use coinsurance in many instances whereas our standard plans provide copays. Here is a summary comparison:

	Proposed plan design: <b>coinsurance</b>	HBX standard plan design: <b>copays</b>
Gold	Lab tests x-rays Diagnostic imaging Imaging (CT/PET scans, MRIs) Outpatient surgery Emergency room Hospitalization Skilled nursing care	Lab tests x-rays Diagnostic imaging Imaging (CT/PET scans, MRIs) Outpatient surgery Emergency room Hospitalization Skilled nursing care
Silver	Lab tests x-rays Diagnostic imaging Imaging (CT/PET scans, MRIs) Outpatient surgery Emergency room Hospitalization Skilled nursing care	Lab tests x-rays Diagnostic imaging Imaging (CT/PET scans, MRIs) Outpatient surgery Emergency room Hospitalization Skilled nursing care
Expanded Bronze	Lab tests x-rays Diagnostic imaging Imaging (CT/PET scans, MRIs)	Lab tests x-rays Diagnostic imaging Imaging (CT/PET scans, MRIs)

Copays provide the consumer with an amount certain they will expend on a particular service. Coinsurance does not provide that certainty and therefore doesn't help the consumer compare plan features. Plans have different negotiated rates with different providers. For example, a psychologist will have a different negotiated rate with different health plans. Even when co-insurance percentage is the same among plans, the patient will pay a different dollar amount depending on the negotiated rate and the plan the consumer is enrolled in. In other words, comparing standard plans with the same coinsurance is not going to help the consumer because ultimately, the service will have a different cost depending on the negotiated rate. Copays provide the best certainty for consumers.

HBX encourages CMS to reconsider its standard plan designs to ensure consumers have access to basic, essential care without financial barriers that high deductibles pose and that consumers can easily compare plans having as many as possible copay features instead of coinsurance features.

### **Quality Improvement Activities and Medical Loss Ratio Reporting (§ 158.150)**

CMS proposes to specify that only expenditures directly related to activities that improve health care quality may be included in Quality Improvement Activities (QIA) expenses for medical loss ratio (MLR) reporting and rebate calculation purposes.

We support CMS's on-going efforts to clarify allowable QIA activities for MLR purposes and encourage CMS to clarify that activities related to addressing health disparities should be included in QIA. Issuers are critical to help address existing health disparities. Many issuers are already engaged in activities to address health disparities. To incentivize all issuers to prioritize activities designed to address health disparities and improve outcomes for patients of color, CMS should define QIA activities related to health disparities as broadly as possible. Consequently, issuers could then focus more resources and make additional investments, even investments that are arguably indirectly related to health disparities, such as providing scholarships for students of color interested in STEM. (Note that our position is that such scholarships are directly related to addressing health disparities.)

CMS has already clarified that health equity activities are directly related to quality improvement, and 45 C.F.R. §158.150(b)(2)(i) allows some issuer activities related to health equity to be included as quality improvement activities in an issuer's MLR. The activities must be primarily designed to improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.<sup>35</sup>

CMS should clarify that allowable QIA expenses include all expenses related to health equity and disparities work in which issuers are engaged.

As we discussed earlier, in July 2021, HBX's Executive Board adopted the unanimous recommendations of our Social Justice and Health Disparities Working Group to reduce health disparities in the District. Those include new requirements on our issuers. It is unclear if none, some, or all of those activities are allowable in the computations of the issuers' MLR under the existing regulation. We consider all of these requirements critical to addressing health disparities and request that CMS clarify that all of these activities would qualify under allowable QIA.

Here is a summary of the requirements.

1. To Expand access to providers and health systems for communities of color in the District, issuers will:
  - Provide incentives for both primary care and specialist physicians to practice in underserved areas in DC;

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<sup>35</sup> 45 C.F.R. § 158.150(b)(2)(i).



- Support access to diverse medical professionals: Provide scholarships for STEM students and medical school students of color in health professional schools in the District;
- Review provider networks to determine the race, ethnicity and primary language of their providers to establish a baseline and develop 5-year goals to improve the diversity of the networks.

These activities are a necessary step to achieving health equity. These activities seek to address the lack of health professionals who are people of color and the lack of providers in certain parts of the District. It is not clear how these activities fit within the examples CMS provided in the regulation as allowable QIA activities for MLR computation.

2. To eliminate health outcome disparities for communities of color in the District, issuers will:

- Collect and use comprehensive, member-level racial, ethnic and primary language data to support and collaborate with network providers to reduce racial and ethnic inequities;
- No later than Plan Year 2023, obtain race, ethnicity, and language data directly from members via mail, email, telephone and electronic portals, and other mechanisms. Share with HBX baseline metrics for data collection, annual goals and, beginning in Plan Year 2024, progress in meeting such goals;
- Provide aggregate data by race, ethnicity, and primary language to HBX for select diseases and health conditions, in consultation with HBX.

Current regulatory language states: “Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.”<sup>36</sup> HBX believes that the collection and analysis of data on race, ethnicity, and primary language is necessary to evaluate the effectiveness of identified best clinical practices and evidence-based medicine, and is therefore allowable. We seek confirmation that the activities we list above are allowable.

In addition, as we discussed earlier, we are changing our standard plan design to provide coverage with no cost-sharing for conditions that disproportionately impact communities of color. This effort will involve significant investments by our health plans including potential changes in billing codes to ensure zero cost-sharing and significant provider education to ensure providers use correct billing codes. We also anticipate significant new resources to handle appeals related to improper coding. These are just a few examples of resources that our health plans will have to invest to implement new plan design to address health disparities. If these expenses are not allowed in QIA, it will be very difficult to use plan design to address health disparities. We seek confirmation that these and other activities our issuers are engaged in to address health disparities in the District are allowable as QIA expenses.

3. To ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District, issuers will:

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<sup>36</sup> 45 C.F.R. § 158.150(b)(2)(i)(A)(2).

- Require network providers to complete cultural competency training, which should reflect widely available, recommended resources and tools to mitigate implicit bias;
- Provide and require cultural competency training to support the delivery of culturally and linguistically competent services, in adherence to the Department of Health and Human Services Office of Minority Health’s A Physician’s Practical Guide to Culturally Competent Care and other resources listed by CDC’s National Prevention Information Network;
- Require cultural competency training annually for all providers in network;
- Offer incentives to encourage non-network providers to complete training;
- Require cultural competency training in provider contracts, which should be tailored to both primary care physicians and medical specialists;
- Obtain the National Committee for Quality Assurance’s (NCQA’s) Multicultural Health Care distinction;
- Review clinical algorithms and diagnostic tools for biases and inaccuracies and update appropriately;
- Conduct and report to HBX an assessment of clinical management algorithms that may introduce bias into clinical decision making and/or influence access to care, quality of care, or health outcomes for racial and ethnic minorities. Within one year, issuers will report the outcomes of such assessments to HBX, as well as plans and timeline for correction, as necessary;
- Within one year, prohibit use of race in estimating glomerular filtration rate (GFR) by hospitals, laboratories, and other providers in network, in alignment with guidelines promulgated by the National Kidney Foundation.

The activities necessary to effectuate the recommendations regarding cultural competency might be allowable under subsection (I) above: “Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives...”. HBX believes that cultural competency training is essential for issuers to provide effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, and is therefore allowable. It would help for CMS to clarify.

We believe that some of these activities, e.g. accreditation fees, are allowable under current regulations. However, it is not clear whether all of the above listed activities are allowable. For example, recent studies have demonstrated that bias in algorithms and other clinical decision-making tools used in health care settings can exacerbate health disparities.<sup>37</sup> One example of this is the recently updated guidelines for kidney function testing, which was updated to remove race adjustments that resulted in patients of color being denied needed care.<sup>38</sup> Issuers are key in helping to identify and eliminate the use of such biased clinical decision-making tools. Again, we seek clarification that all the above activities are allowable under QIA. To incentivize issuers

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<sup>37</sup> Katherine Igoe, “Algorithmic Bias in Health Care Exacerbates Social Inequities — How to Prevent It,” Harvard T.H. Chan School of Public Health (March 12, 2021), available at <https://www.hsph.harvard.edu/ecpe/how-to-prevent-algorithmic-bias-in-health-care/>

<sup>38</sup> “NKF and ASN Release New Way to Diagnose Kidney Diseases,” National Kidney Foundation (Sept. 23, 2021), available at <https://www.kidney.org/news/nkf-and-asn-release-new-way-to-diagnose-kidney-diseases>

to invest in health equity activities, it is crucial for CMS to define QIA activities related to health disparities in the computation of an issuer's MLR as broadly as possible.

### **Part III**

#### **Guaranteed Availability of Coverage – Past Due Premiums (§ 147.104(i))**

We support CMS's proposal to clarify that a health insurance issuer violates the Guaranteed Availability requirement at 45 C.F.R. § 147.104(a) when the issuer denies coverage to an individual or employer based on the individual or employer's failure to pay past premiums or where the issuer "attribute[s] payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance . . . ." <sup>39</sup>

HBX strongly opposed the interpretation of 45 C.F.R. § 147.104(a) contained in the preamble to the 2017 Market Stabilization Rule, which permitted issuers to deny coverage to consumers during open enrollment if they owed past-due premiums. The 2017 interpretation violated the statute, was unsupported by evidence, and was bad public policy penalizing working Americans with income fluctuations, especially those who are self-employed or work multiple jobs without job-based coverage.

Following CMS's 2017 rule, the HBX Executive Board adopted a resolution based on recommendations of our Standing Advisory Board, which includes representatives of health plans, brokers, physicians, consumer advocates, and patient advocates. Our Board asked our insurance department to prohibit issuers from denying coverage based on prior owed premiums.<sup>40</sup> Furthermore, in our discussions with DC Health Link health plans, we clarified that they needed to continue to comply with guaranteed-issue requirements. Although in DC we prevented residents and employers from being shut out of the private health insurance market, people and businesses in states that allowed issuers to reject people from coverage did not have state or federal protections.

As we stated in our comments to the 2017 rule, CMS's interpretation violated the guaranteed availability requirement in Section 2702 of the Public Health Service Act. Section 2702 provides that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." The requirement to accept all applicants for coverage does not include an exception for terminations based on nonpayment of premiums in the past year. Creating such an exception required reading into law restrictions and conditions that do not exist in statute. CMS did not have authority to amend the statute. As such, the 2017 Rule was arbitrary and capricious, exceeding agency authority under *Chevron, U.S.A. v. National Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

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<sup>39</sup> 87 Fed. Reg. at 720 (to be codified at 45 C.F.R. § 147.104(i)).

<sup>40</sup> HBX Executive Board Resolution (June 14, 2017), available at <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/Resolution%20-%20past%20due%20premiumsfinal%20as%20amended.pdf>.

The 2017 interpretation also contradicted a long history of similar guaranteed-issue requirements under federal law (HIPAA) and the National Association of Insurance Commissioners' (NAIC) Small Employer Health Insurance Availability Model Act. HIPAA established a guaranteed availability requirement in the small group market. Under HIPAA rules,<sup>41</sup> health insurance issuers were required to offer for sale all products actively marketed in the small group market to all small businesses, regardless of health status, with limited exceptions. Issuers are permitted to deny coverage in limited circumstances based on geographical restrictions, financial capacity limits, or failure to meet minimum participation or contribution requirements. HIPAA did not allow health insurance issuers to deny coverage on the grounds that an employer owed past due premiums.

The 2017 Rule forced people to be uninsured and was bad public policy – especially during an on-going pandemic. The 2017 Rule harmed consumers by creating new barriers to medical care, and a new risk of financial ruin, by forcing people to be uninsured. Studies show that being uninsured is a cause of preventable deaths. In a 2009 study, researchers found that almost 45,000 annual deaths were associated with a lack of health insurance.<sup>42</sup> More recent studies have continued to link a lack of insurance with increased rates of death.<sup>43</sup> Further, research conducted during the COVID-19 pandemic found that from the start of the pandemic through August 31, 2020, each 10% increase in the proportion of a county's residents lacking health insurance was associated with a 70% increase in COVID-19 cases and a 48% increase in COVID-19 deaths (even when controlling for a range of factors).<sup>44</sup> Studies also show that medical debt remains a serious contributor to personal bankruptcy and that Americans continue to fear financial ruin due to medical expenses.<sup>45</sup>

Now, more than ever, CMS and states need to reexamine all regulatory impediments to enrollment in affordable quality coverage -- a lifeline especially during a pandemic. We urge CMS to adopt its proposal to clarify that a health insurance issuer violates the Guaranteed Availability requirement at 45 C.F.R. § 147.104(a) when the issuer denies coverage to an individual or employer based on the individual or employer's failure to pay past premiums or where the issuer "attribute[s] payment of premium for a new policy, certificate, or contract of insurance to the prior policy, certificate, or contract of insurance."<sup>46</sup>

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<sup>41</sup> 45 C.F.R. § 146.150.

<sup>42</sup> See Wilper, Woolhandler, Lasser, McCormick, Bar, and Himmelstein, "Health Insurance and Mortality in US Adults," *Am J Public Health* (December 2009).

<sup>43</sup> See, e.g., Woolhandler and Himmelstein, "The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?" *Annals of Internal Medicine* (Sept. 2017), *available at* <https://www.acpjournals.org/doi/10.7326/m17-1403>.

<sup>44</sup> "The Catastrophic Cost of Uninsurance: COVID-19 Cases and Deaths Closely Tied to America's Health Coverage Gaps," *Families USA* at 2 (March 2021), *available at* [https://familiesusa.org/wp-content/uploads/2021/03/COV-2021-64\\_Loss-of-Lives-Report\\_Report\\_v2\\_4-20-21.pdf](https://familiesusa.org/wp-content/uploads/2021/03/COV-2021-64_Loss-of-Lives-Report_Report_v2_4-20-21.pdf).

<sup>45</sup> See Bennett, Eggleston, Mykyta and Sullivan, "19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away," *United States Census Bureau* (April 7, 2021), *available at* <https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html>; Witters, "50% in U.S. Fear Bankruptcy Due to Major Health Event," *Gallup* (Sept. 1, 2020), <https://news.gallup.com/poll/317948/fear-bankruptcy-due-major-health-event.aspx>; Faye, "Bankruptcy Statistics," *Debt.Org* (Dec. 14, 2021), *available at* <https://www.debt.org/bankruptcy/statistics/>.

<sup>46</sup> 87 Fed. Reg. at 720 (to be codified at 45 C.F.R. § 147.104(i)).

## **Nondiscrimination (45 C.F.R. §§ 147.104(e), 155.120, 155.206, 156.125; 156.200, 156.1200)**

HBX strongly supports the proposed amendments to reinstate the protections against discrimination on the basis of sexual orientation and gender identity. HBX opposed the 2019 regulations that removed those protections from section 1557 regulations, and we strongly support CMS using their existing authority to clearly state that discrimination based on these grounds is prohibited by health insurers, exchanges, and agents and brokers. We also urge the HHS Office of Civil Rights to issue guidance similar to CMS's proposed guidance and to repeal the 2019 section 1557 regulations that denied civil rights protections to millions of people.

The District of Columbia has been a leader in addressing discrimination related to gender identity and expression. Working with HBX, the Department of Insurance, Securities and Banking (DISB) issued guidance to clarify that health insurance issuers are prohibited from discriminating on the basis of gender identity or expression and specified that "exclusionary clauses that discriminate on the basis of 'gender identity or expression' are *prima facie* prohibited...". DISB also clarified that "attempts by companies to limit or deny medically necessary treatments for gender dysphoria, including gender reassignment surgeries" would be viewed as discriminatory.<sup>47</sup>

HBX continues to work to ensure equitable access to care for all communities that have been historically disadvantaged and we applaud this important step by CMS to root out discrimination based on sexual orientation or gender identity.

## **Display Standards for Agents, Brokers, and Web-Brokers (§ 155.220(c)(3)(i))**

HBX supports the proposals to set pro-consumer website display standards for agents, brokers, and web-brokers. However, as we wrote in our prior comments, we believe that any use of web-based brokers raises substantial fraud and abuse concerns. HBX continues to believe consumers are better served by shopping directly through ACA exchange marketplace websites. Nonetheless, the proposed information display requirements, prohibition on advertisements or preferential QHP display, and requirement to explain QHP recommendations or default displays are a step in the right direction toward increasing transparency of information and reducing abusive web-broker activity.

First, the proposal reduces misinformation by specifying that information must be drawn directly from the issuer or the exchange website, with a CMS-approved message telling the customer they can go to the exchange website for enrollment support. Second, the proposed prohibition on QHP's advertising and preferential QHP display on web-broker sites is necessary to remove bias in the shopping experience. Third, the proposal to require web-broker websites to prominently display a clear explanation of the rationale for explicit QHP recommendations and the methodology for the default display of QHPs on their websites is also necessary to remove bias in the shopping experience. These proposed standards further protect consumers from being steered into coverage based on commissions or other financial incentives.

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<sup>47</sup> District of Columbia Department of Insurance Securities and Banking, Bulletin 13- IB-01-30/15 Revised (February 27, 2014).

## **Standardized Plan Options**

### *Standardized Options (§ 156.201)*

CMS has proposed to require issuers of QHPs in FFEs and SBE-FPs, for PY 2023 and beyond, to offer through the Exchange standardized QHP options at every product network type, metal level, and throughout every service area that they offer non-standardized QHP options. We support this proposal to empower consumers to make more informed choices. We have had standard plans in our individual marketplace since plan year 2016. And we are deploying standard plan design for our SHOP for plan year 2023. Our standard plan features require some deductibles, copays, and coinsurance, we don't allow benefit substitutions for essential health benefits, and certain benefits in addition to preventive care must be covered pre-deductible. This standard plan design helps our customers compare options based on quality, provider networks, and price.

And to simplify the shopping experience and comparison, we have DC Health Link Plan Match tool powered by CONSUMERS' Checkbook. In fact, in 2017 and 2018, we ranked number one among all SBMs and the federal marketplace for our consumer decision support tools.<sup>48</sup> Plan Match uses a sophisticated and seasoned algorithm that enables our customers to compare plans based on total out-of-pocket costs (not just premiums), taking into consideration expected health care needs. Importantly, our customers when shopping can include their doctors and look up how and if their prescription medications are covered. The Rx look up tool allows customers to include up to 10 medications with exact dosage. Based on these search criteria, instantly our customers can see how plans compare. Having a standard plan design and effective consumer decision support tools has greatly simplified the complexities of health insurance and has made shopping for coverage easier.

In addition, standard plan design has made it easier for our assisters and DC Health Link brokers to explain differences in plan choices to our customers who prefer or need in-person help.

We applaud the proposed requirement for standardized plans and encourage CMS to couple it with enhanced consumer decision support tools.

### *Differential Display (§ 155.205(b)(1), 155.220, 156.265)*

CMS is considering displaying standardized plans differently on HealthCare.gov, requiring approved web-brokers and direct enrollment issuers to display standardized options consistent with how standardized options are displayed on HealthCare.gov unless CMS allows a deviation, and resuming enforcement of the standardized options display requirements.

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<sup>48</sup> Press Release, Council for Affordable Health Coverage (Jan. 31, 2017), *available at* [https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event\\_content/attachments/Clear%20Choices%20Press%20Release%20Exchange%20Report%20Card%202017.pdf](https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Clear%20Choices%20Press%20Release%20Exchange%20Report%20Card%202017.pdf); Blog Post, Council for Affordable Health Coverage (Oct. 29, 2018), *available at* <https://www.cahc.net/newsroom/2018/10/29/new-report-highlights-shortcomings-on-healthcaregov-state-based-exchanges-ahead-of-open-enrollment-season>.

We support displaying standardized plan options differentially. DC Health Link’s Plan Match tool displays all standard plans with a green ribbon and allows users to sort and filter for standard plans. All standard plans include the word “standard” in their plan name. Each plan also links to the Summary of Benefits and Coverage, which highlights standard plan benefits that are covered pre-deductible. We also explain to customers what standard plans are and the benefits of choosing a standard plan. A consumer can see in a hover over link the following explanation:

The screenshot shows a user interface for selecting a health plan. On the left, there are two filter sections: "Standard Plan" with a green checkmark and a green ribbon icon, and "Metal Level" with three radio button options: Platinum, Gold, and Silver. A dark blue tooltip box is overlaid on the right side of the screen, containing the following text:

A standard plan covers many in-network medical services without you having to meet the deductible first\*. This includes primary care visits, specialist visits, mental health services, generic prescription drugs, and urgent care.

Each health insurance company in the Individual & Family market offers a standard plan at each metal level. These plans have the same out-of-pocket costs for an in-network provider. For example, a primary care visit will have a \$40 copay for any silver standard plan, whether you choose CareFirst BlueCross BlueShield or Kaiser Permanente. This makes it easier to compare plans. The major differences between standard plans at the same metal level are monthly premiums and provider networks.

\*Note: If you choose an HSA high deductible health plan, you’ll still need to meet the deductible first because of IRS rules.

Below the tooltip, the text "ANNUAL PREMIUM: \$1,515.48" is partially visible.

These special display features help consumers to know that standard plans are available, to better understand coverage benefits of standard plans, and to simplify the shopping experience when comparing plans.

In addition, once a customer is logged into their account and is shopping, we display standard plans first and each one has a box highlighting that it’s a standard plan:



We strongly support CMS requiring web-based brokers and direct enrollment entities to display standard plans the same way that HealthCare.gov displays and oppose allowing deviations. Consumers relying on such private entities should not be deprived of the decision-making tools available to consumers who use HealthCare.gov. Any deviations in display can also lead to confusion. One of the benefits web-based brokers have promoted is their superior IT systems. CMS should hold these “superior IT systems” to the same standards and not lesser standards.

### **Annual Reporting of State-Required Benefits (§ 156.111(d) and (f))**

HBX strongly supports CMS’s proposal to remove the annual requirement that states must report state-required benefits to HHS in addition to the EHB. As we wrote in response to the 2021 NBPP proposed rule, the reporting requirement finalized in 45 C.F.R. § 156.111(d) and (f) under the 2021 NBPP final rule<sup>49</sup> imposed new regulatory burdens on states. The burdensome reporting structure devised in that rule would have required state officials to either procure consultants or divert existing staff from other work to comply with an entirely new reporting process.

We agree with CMS’s proposal to continue to “engage in technical assistance with states to help ensure state understanding of when a state-benefit requirement is in addition to EHB and requires defrayal.” We appreciate CMS’s commitment to provide written technical assistance and outreach that clarifies CMS’s defrayal policy and fosters states’ understanding of how HHS analyzes -- and expects states to analyze -- whether a state-required benefit is in addition to EHB pursuant to § 155.170.<sup>50</sup> CMS’s current proposed approach would help CMS to address any compliance concerns with individual states without imposing new administrative burdens on all states.

### **Solicitation of Comments on Health Equity, Climate Health, and Qualified Health Plans**

HBX strongly supports CMS’s goals to advance equity and improve health outcomes for all people. HBX is committed to addressing long-standing health disparities and health care inequities in the District. Although these problems are complex and require comprehensive approaches, HBX and our DC Health Link health plans can be part of the solution. We’ve detailed in other parts of this comment letter the critical work we are doing to 1) expand access to providers and health system for communities of color in the District, 2) eliminate health outcome disparities for communities of color in the District, and 3) ensure equitable treatment for patients of color in health care settings and in the delivery of health care services in the District. We look forward to working with CMS to address systemic institutional racism and discrimination and bias based on race, ethnicity, gender, disability, sexual orientation, gender identity or other characteristic historically linked to discrimination.

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<sup>49</sup> 85 Fed. Reg. 29,164 (May 14, 2020).

<sup>50</sup> 87 Fed. Reg. at 662.



## **Conclusion**

Thank you for considering our comments on issues that will directly impact District residents and the continued operations of our marketplace. We appreciate CMS's continued support for state flexibility, consumer protections, and working to ensure a more equitable future. We look forward to working with you on these issues.

Sincerely,

Mila Kofman, J.D.  
Executive Director  
DC Health Benefit Exchange Authority