DC Health Benefit Exchange Authority

March 12, 2026

Peter Nelson, J.D.,
Director, CCIIO
Centers for Medicare & Medicaid Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program [CMS-9883-P]**

Dear Director Nelson:

The DC Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments.

By way of background, HBX is a private-public partnership established by the District of Columbia to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). HBX is governed by a private Executive Board. We cover approximately 115,000 people – District residents and 5,300 small businesses and non-profits. We are also the designated source of coverage for Members of Congress and their designated staff. We foster 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 on October 1, 2013, we have cut the uninsured rate by 50% and now approximately 97% of District residents have health coverage.

Revisions to 45 C.F.R. 155.170(a) – State benefit mandates and defrayal

CMS proposed to revise section 45 C.F.R. 155.170(a) to require states to defray costs for any state-mandated benefits that are considered to be "in addition to EHB," even when those benefits are included in the state's benchmark plan. Under the proposed regulations, the District of Columbia, and other states, will be faced with new financial costs or the decision to repeal critical benefits for residents and small businesses. Furthermore, this proposal represents a significant reversal of prior CMS policy on which the District and other states reasonably and actively relied.

In 2018, the first Trump Administration gave states flexibility to revise and update their EHB benchmark plan on an annual basis beginning with the 2020 plan year. This was followed by a 2018 FAQ where CMS confirmed that states updating their EHB benchmark plans would not trigger new defrayal obligations for benefits incorporated in those plans through the benchmark update process. That guidance made clear that benchmark plan selection alone does not create

new state mandates for purposes of the defrayal framework at §155.170 and encouraged states to make changes to their benchmarks to expand coverage for substance abuse disorder in response to the opioid crisis.[1] Then, in the 2025 Payment Notice, CMS explicitly finalized regulations clarifying that covered benefits in a state's EHB benchmark plan are considered EHB and therefore exempt from defrayal.[2] While we support the goal of safeguarding federal tax dollars and promoting affordable coverage, we urge CMS to consider alternative approaches that will allow medical innovation to thrive and private health insurance benefit design to keep up with important medical breakthroughs.

The District has been judicious about adding new benefit mandates to private health insurance coverage. In fact, while many benefit mandate bills have been introduced since 2011, only one passed and imposed a new benefit requirement. With significant medical advances made to help women and families get pregnant and have children, District policymakers passed a requirement applicable to large group, small group, and individual private health insurance to cover fertility treatment, including in-vitro fertilization (IVF), fertility preservation services, and fertility enhancing medication. This was a benefit offered by large employers but not offered in the individual or small group market.

On February 18, 2025, President Trump recognized the importance of IVF in health care coverage. Through Executive Order "Expanding Access to In Vitro Fertilization," the President made it a policy of the Administration to "ensure reliable access to IVF treatment, including by easing unnecessary statutory and regulatory burdens to make IVF treatment drastically more affordable."[3]

The District's new benefit became effective January 1, 2025 and nearly 1,000 families have benefited including employees of District small businesses, Congressional enrollees, and District residents enrolled on the individual and family marketplace.[4] Families were faced with tens of thousands of dollars in out-of-pocket costs prior to this benefit mandate. At the hearing on this legislation, witnesses shared personal stories of financial, physical, and emotional hardship.

One witness said:

> The average IVF treatment, a process which my husband and I went through three times, is around $14,000 but in the DC area, we were quoted prices around $30,000 including the medications. That does not include services like PG testing which was critical for my husband and myself as we experienced recurrent pregnancy loss due to chromosomal issues with our embryos. As my husband and I experienced our painful losses at 6, 8, and 10 weeks, we weighed either buying a house – allowing us to put down long-term roots

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[1] Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (Oct. 23, 2018), available at https://www.cms.gov/files/document/faqs-defrayal-state-additional-required-benefits.pdf.

[2] *HHS Notice of Benefit and Payment Parameters for 2025*; Final Rule, 89 FR 26264 (April 15, 2024).

[3] Expanding Access to In Vitro Fertilization, Executive Order 14216, Feb. 18, 2025 available at https://www.federalregister.gov/documents/2025/02/24/2025-03064/expanding-access-to-in-vitro-fertilization.

[4] Source: Validated claims filed by covered people – small businesses, Congressional enrollees, and individual market enrollees.

> in the place that six generations of my family have called home – or to fund an IVF cycle. No woman or family should have to make that choice.

Another witness shared:

> I am 1 in 4 women who has experienced a miscarriage. This is because my husband is 1 in 800 people who suffer from a rare genetic condition known as a balanced chromosome translocation. If we tried to conceive naturally, at best, we would have 1 in 8 odds of bringing home a healthy baby. Often, couples with this diagnosis experience double digit miscarriages, and the physical and emotional trauma to accompany them, in their efforts to build their families. For couples like us, this makes IVF… the best shot for safely conceiving a healthy baby. We always envisioned our family with two children, and having biological children remains a priority and an important part of our identity as a couple. When we decided that IVF was the right path for us, we quickly learned we had no access to health insurance that would provide even partial coverage for fertility treatment. I am the part-owner of a small business founded here in Washington, DC. … Only because we were fortunate enough to have the means to pay out of pocket for fertility treatment, I am now an IVF mom. My rainbow baby turns one on Thursday. It took us two egg retrievals and two frozen embryo transfer cycles to bring my daughter home. She has brought such joy into our lives that earlier this year, we pursued IVF again to try to make her a sibling. While we are still in the process of completing our family, to date, our testing, treatments, and medication have cost us roughly $70,000 out of pocket, an investment that is unfathomable for many families in the district, especially in today's economic environment….

We have many customers who are now relying on this benefit and at risk of losing it. We relied on the 2018 and 2024 federal guidance and regulatory changes and expeditiously took all necessary steps to update our EHB benchmark plan to ensure this benefit was considered EHB and exempt from defrayal starting in plan year 2026. We received approval from CMS in 2024 for our updated EHB benchmark.

- If the current proposal is finalized as proposed, women and families in need of IVF are at risk of losing these benefits mid-treatment, adversely impacting their health and ability to have children.

Making medical care more unaffordable also adds financial strain. The proposed regulatory change would result in higher health care costs for IVF services at a time when President Trump has championed the inclusion of IVF in health care coverage.

We urge CMS to reconsider its proposed approach and offer the following alternatives that balance the need to have affordable health insurance premiums and ensure appropriate use of federal subsidies (APTC) with the need to make health care more affordable for families that would like to have children. The proposed options also recognize the need to eliminate friction added by government that discourages innovation – in this case the medical breakthroughs over the last several decades for fertility treatment.

Alternative approaches:

- ✓ Grandfather states that updated their EHB benchmark plans and received approval from CMS under the 2024 change in regulation. After the rule becomes effective for future plan years, any new mandates added to a state's EHB benchmark plan would be subject to the defrayal requirements. This option helps states including the District that relied on the 2024 regulatory change. It also makes it clear to states that new mandates must be paid for.

- ✓ Consistent with and supported by President Trump's Executive Order on the importance of fertility treatment for American families, allow a safe harbor from defrayal for fertility treatment mandates for all states that have passed fertility treatment requirements. Medical innovation and advances in IVF and other fertility services now far surpass available treatments in 2011 or earlier. A limited safe harbor eliminates regulatory friction to innovation. In the alternative, limit a safe harbor for states that have already updated their EHB benchmark plans to include this care. The safe harbor would only be for fertility treatment coverage that is reflected in state benchmark plans.

- ✓ Limit defrayal obligations to benefit mandates enacted after the date of the final rule and provide a minimum two-year transition period before defrayal obligations attach to such mandates. States that received CMS benchmark approval prior to the final rule's publication would be held harmless for benefits included in the approved EHB benchmark plans indefinitely. This directly addresses the retroactivity problem without requiring CMS to carve out specific benefit categories and aligns with the proposed rule's discussion of a PY 2028 effective date.

We appreciate your consideration of these alternative approaches.

Request for Comments: Section 71303

CMS is requesting comments on the implementation of Section 71303 of the Working Families Tax Cut (WFTC) legislation. Section 71303 amends Section 36B of the Internal Revenue Code to establish new requirements for eligibility for advanced premium tax credits (APTC) for plan year (PY) 2028. Before a taxpayer can get APTC, an Exchange must verify section 71303 enrollment information either provided or verified by the applicant. The enrollment information includes, at a minimum, affirmation of household income and family size, whether the individual is an eligible alien, health coverage status or eligibility for coverage, and place of residence. The new standard also allows the Secretary of the Treasury, in consultation with the Secretary of HHS, to require other information. SBMs must operationalize Section 71303 by August 1, 2027 for PY 2028 coverage. This statutory deadline requires Exchanges to stand up a new, distinct process separate from current enrollment-time verification workflows.

Because CMS has not yet proposed implementing regulations for Section 71303 and instead seeks comment to inform future rulemaking, early issuance of final guidance is essential to allow time for IT and operational changes, as well as budgetary planning. Our code freeze begins October 1 and ends in February every year. We do not make IT changes during code freeze in

order to mitigate risk of disruption to open enrollment and open season for different populations we serve – DC residents, DC small businesses, and Congress. To budget, develop, test, and deploy major changes, we need time. Even small changes require us to shift other IT development work. For changes that can build on our existing infrastructure, final guidance on Section 71303 issued by July 2026 is critical for us to deploy a compliant pre-enrollment verification process by the statutory deadline of August 1, 2027. More extensive changes requiring new system architecture would require final guidance earlier or a phased implementation deadline.

In developing its implementing guidance, we request CMS to recognize different approaches that effectively safeguard taxpayer dollars and meet the requirements of section 71303. Depending on allowed approaches, IT and other changes could cost us tens of millions of dollars in new one-time and on-going costs to re-architect our system, while a cost-effective approach that builds on existing infrastructure might be estimated to cost under a $1 million while still meeting the verification requirements for the approximately 3,000 DC residents currently receiving APTC. We can be ready for 71303 compliance if we get final guidance soon and have flexibility for a cost-effective, compliant approach that safeguards taxpayer dollars. We look forward to working with the CMS team on the details of our approach.

**Conclusion**

Thank you for considering our comments. We believe that state flexibility has allowed us to develop policies that work well for our residents and employers we serve, keep our risk pools stable, enable us to operate efficiently, and safeguard taxpayer dollars. We look forward to working with you.

Sincerely,

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