DC Health Benefit Exchange Authority

March 7, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9929-P
P.O. 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; Market Stabilization- CMS-9929-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (DCHBX) appreciates your consideration of our comments on CMS's proposed market stabilization rule.

By way of background, DCHBX is a private-public partnership established by the District of Columbia (District) Council to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). 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 October 1, 2013 when DC Health Link opened for business, approximately **307,478** people have enrolled in private health insurance or were found eligible for Medicaid coverage through DC Health Link. Leveraging the Affordable Care Act and DC Health Link, the District now has the lowest uninsured rate we've ever had. More than 96% of District residents now have health coverage.

A spring 2016 external survey of DC Health Link customers found that:

- 1 in 4 people who signed up for private health insurance were uninsured prior to enrollment;
- 1 in 2 people eligible for Medicaid were previously uninsured; and
- 4 in 10 small businesses did not offer health insurance to their employees prior to enrolling through DC Health Link.

Additionally, in our small group marketplace, we have seen real competition, with all insurers offering some products with lower rates than in 2016 and one insurer decreasing their 2017 rate for a product by 19%. For small businesses we offer 151 different products from two Aetna Companies, three United Companies, Kaiser, and CareFirst. For the first time small businesses have the same type of purchasing power as large employers and can offer the type of choices that large companies offer. For individuals we offer 20 different products from Kaiser and CareFirst.

Market Stabilization and State Flexibility

CMS through this proposed rule seeks to "promote stability in the individual insurance market." We agree with the goal and look forward to working on solutions that would stabilize markets.

However, the proposed rule, if implemented, could have unintended consequences causing instability in the individual market by creating numerous additional barriers that would discourage healthy and young people from enrolling.

Key to market stability is flexibility for states to adopt appropriate interventions to ensure stable markets that work for consumers. States have made numerous decisions working with diverse stakeholders, to ensure that their policies and operations reflect local market conditions and are based on community and market support. States built on-line marketplaces to reflect state and local priorities and laws.

We appreciate that the role of states is recognized and strongly promoted. Executive Order 13765, issued January 20, 2017, instructs agencies to "provide greater flexibility to States and cooperate with them in implementing healthcare programs."

Our goal is to have a stable marketplace and avoid unintended consequences of a one-size-fits-all federal government solution. We are concerned that the proposed rule will result in market disruptions adversely impacting DC residents. States are in a much better place than CMS to understand local health insurance markets, and we are very concerned that the proposed rule takes away state flexibility.

Guaranteed Availability (45 C.F.R. §147.104)

DCHBX strongly opposes the proposal to permit carriers to deny coverage to consumers who apply during open enrollment unless they pay past-due premiums on coverage terminated due to non-payment from the previous year. This proposal violates the current statute, is unsupported by evidence, and would be detrimental to working Americans, especially those who are self-employed or work multiple jobs without job-based coverage. The proposal would have an unintended consequence of leading to market instability. Most importantly, the proposal will prevent individuals from getting life-saving medical care because people will be denied access to private health insurance.

The proposal violates the guaranteed availability requirement in Section 2702 of the Public Health Service Act. Section 2702 provides that "subject to subsections (b)-(e), 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" (emphasis added). The requirement to accept all applicants for coverage does not include an exception for terminations based on nonpayment of premiums in the past year. If adopted, this agency action would entail reading into law restrictions and conditions that do not exist in statute. CMS does not have authority to amend the statute. If adopted, this proposal would be arbitrary and capricious, exceeding agency authority under *Chevron, U.S.A. v. National Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

This interpretation also contradicts a long history of similar guaranteed-issue requirements under federal law (HIPAA) 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 this provision and its regulations, 45 C.F.R. §146.150, health insurance carriers were required to offer for sale all products actively marketed in the small group market to all small employers, regardless of health status, with limited exceptions. Carriers were 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 authorize health insurance carriers to deny coverage

on the grounds that an employer owed past due premiums.

CMS does not provide evidence to support the proposal. DCHBX's experience shows that people miss payments, and get terminated, because they suffer income loss due to life and business events such as divorce, death of a family member, business downturns, or self-employed income fluctuations. We see this when people apply for SEPs. Such SEPs are denied, and consumers have to wait until open enrollment to re-enroll.

The proposal would have unintended consequences, keeping younger and healthier people out of the risk pool. In other words, a requirement to pay back premiums for coverage that did not exist would be a substantial deterrent and would erode the District's risk pool by keeping younger and healthier enrollees out. Our data for 2016 shows termination due to non-payment by age:

Table 1: DC Health Link Individual Marketplace Terminations for Nonpayment, by Age (2016)

AGE GROUP	TOTAL	PERCENT
< 18	327	8%
18-25	295	8%
26-34	1,649	42%
35-44	789	20%
45-54	472	12%
55-64	364	9%
65+	25	1%
TOTAL	3,921	100%

Furthermore, the tax penalties for being uninsured serve as a deterrent to "game" the system, and people are already penalized through tax fines and being uninsured for part of the year.

Finally, the proposal would harm consumers--creating a new and significant barrier 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. See Wilper, Woolhandler, Lasser, McCormick, Bor, and Himmelstein, "Health Insurance and Mortality in US Adults," *Am J Public Health* (December 2009). Studies also show that medical debt and loss of income resulting from illness are the leading cause of personal bankruptcy. See Hummelstein, Thorne, Warren, and Woolhandler, "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine* (2009), available at http://cohealthinitiative.org/sites/cohealthinitiative.org/files/attachments/warren.pdf) And to quote former president George W. Bush, "Americans know economic security can vanish in an instant without health security." State of the Union address (January 29, 2002).

For all these reasons, we urge CMS not to adopt this proposal.

Special Enrollment Periods (45 C.F.R. §155.420)

CMS proposes several new requirements, including pre-enrollment verification, for special

enrollment period (SEP) rights under 45 C.F.R. §155.420. Please see DCHBX's response to the Government Accountability Office (GAO) study that CMS cites to support its SEP proposals (attached).

DCHBX strongly opposes these new requirements and limitations on accessing coverage. Each creates new and burdensome obstacles to enrolling in health insurance coverage. Making it harder for people to enroll will result in young and healthy people deciding to stay uninsured. As shown in Table 2, in the District, customers enrolling through a SEP are younger than people who enroll during open enrollment. Age is a proxy for health. If the new requirements result in younger people not enrolling, premiums will increase, and DC's risk pool will be destabilized.

Table 2: DC Health Link Customers by Age Enrolled in Private Individual Health Insurance in 2016

COVERAGE EFFECTUATED IN 2016		
AGE	Open Enrollment %	SEP %
< 18	9%	11%
18-25	6%	8%
26-34	36%	45%
35-44	21%	18%
45-54	15%	10%
55-64	14%	8%
65+	1%	0%
TOTAL	100%	100%

Each state and each market is different. We urge CMS to continue to support state flexibility, which will enable each state to adopt appropriate policy interventions as necessary and to ensure that the unintended consequence of destabilizing risk pools is prevented.

Metal Level Restrictions

CMS proposes to limit consumers' current rights to change metal levels if they qualify for a SEP. This proposal seems to apply only to the federal platform. DCHBX seeks confirmation in the final rule that it does not apply to SBMs. We urge CMS to continue an approach that results in state flexibility consistent with Executive Order 13765 (January 20, 2017), which instructs agencies to "provide greater flexibility to States and cooperate with them in implementing healthcare programs."

States should be allowed to continue making policy decisions impacting their residents. Where the law allows states to have different standards, DCHBX's Executive Board adopts policies based on recommendations of its Standard Advisory Board, whose members include a health plan, consumer advocates, brokers, small businesses, and others.

Additionally, we believe that if applied in states using the federal platform (Healthcare.gov), this proposal is arbitrary and capricious. It is contrary to longstanding HIPAA SEP rights, which required that eligible people have the same election rights as a regular enrollee, including the right to select from any plan available. CMS has argued that it is not required to extend the

same rights to individual market consumers as are available to people in the group markets, due to real differences between the markets; CMS suggests that it is only required to establish SEP triggers similar to those under HIPAA. However, this argument is inconsistent with the ACA. Section 1311(c)(6)(C) of the ACA specifies that the Secretary shall require exchanges to provide for "special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Social Security Act." The plain language of the statute requires the Secretary to establish special enrollment period rights under federal law, as specified in Section 9801 of the Internal Revenue Code (IRC). CMS' interpretation reads the specific rights in Section 9801 of the IRC out of the law.

Coverage Delays

CMS proposes to limit state flexibility regarding effective dates for SEPs under 45 C.F.R. §155.420((b)(5). DCHBX opposes this proposal, which will hinder SBMs in mitigating harm to customers. By limiting state authority, this proposal conflicts with Executive Order 13765 (January 20, 2017), which instructs agencies to "provide greater flexibility to States and cooperate with them in implementing healthcare programs." We urge CMS to retain state flexibility in accordance with Executive Order 13765.

Prior Coverage Requirements

CMS proposes a new requirement affecting consumers who are eligible for a SEP due to marriage. Under this proposal, newly married people would have to demonstrate that at least one had coverage in the past 60 days. This new requirement contradicts well established federal law under HIPAA. As noted above, Section 1311 of the ACA charges the Secretary with establishing SEPs specified under Section 9801 of the IRC. Under Section 9801 of the IRC, eligibility for a life event SEP (including birth, marriage, adoption, or placement for adoption) is not contingent upon having prior coverage. The proposal to implement a new prior coverage requirement for a life event (marriage) is inconsistent with long established federal law and practice and is an arbitrary and capricious decision exceeding agency authority under *Chevron*.

Additionally, because employers and insurers are no longer required to provide Certificates of Creditable Coverage, people would have no clear way to establish that they had prior coverage. We oppose new requirements that add burdens on employers, individuals, and insurers. We also worry that the proposal would have unintended consequences. Such new requirements would not deter people with medical needs from signing up but could discourage healthy people from signing up.

Continuous Coverage

CMS solicited comments (without defining a specific proposal) about imposing a new continuous coverage requirement to address adverse selection. If adopted, such a requirement would violate the current statute and be detrimental to working Americans. The proposal is contrary to established market practice and could further destabilize markets, especially if young people between jobs, or between school coverage and job-based coverage, choose to be uninsured. A requirement for continuous coverage could have unintended destabilizing consequences for health insurance markets.

Further, if adopted, the proposal would violate the guaranteed availability requirement under Section 2702 of the Public Health Service Act. Section 2702 provides that "subject to subsections (b)-(e), 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" (emphasis added). The requirement on insurers to accept all applicants for coverage does not include a prerequisite of having continuous coverage. Adopting new restrictions would exceed CMS's regulatory authority.

Open Enrollment (45 C.F.R §155.410)

CMS proposed to amend 45 C.F.R. §155.410(e) to shorten the annual open enrollment period for plan year 2018 and subsequent plan years to 45 days (running from November 1, 2017 through December 15, 2017). As proposed, this change would take place one year earlier than is currently planned. DCHBX supports the concerns raised by other state-based marketplaces and the potential negative impact this proposal may have.

Conclusion

HBX supports market-stabilizing solutions, flexibility for states, and policies that help people obtain affordable, quality health insurance. We oppose policies that limit state flexibility, may disrupt stable markets, and create barriers to consumer enrollment in health insurance. Thank you for considering our comments on regulations that will directly impact DC residents and stability of our market. We look forward to working with you on these complex issues to achieve market stability.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority

DC HBX Comment Letter – CMS 9929-P

Attachment 1

DC Health Benefit
Exchange Authority

November 4, 2016

Seto J. Bagdoyan
Director, Forensic Audits
Forensic Audits and Investigative Service
Government Accountability Office
441 G Street NW
Washington, DC 20548

Re: Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period (GAO-17-78)

Mr. Bagdoyan:

Thank you for the opportunity to respond to the DRAFT report, *Patient Protection and Affordable Care Act: Results of Enrollment Testing for the 2016 Special Enrollment Period (GAO-17-78)*, received from the Government Accountability Office (GAO) on October 18, 2016. The draft report looks at the federal marketplace and two state-based marketplaces (SBMs), one of which is the District of Columbia's.

The DC Health Benefit Exchange Authority (DCHBX) is a public-private partnership created by the District Council to implement a State-based marketplace (SBM) under the Affordable Care Act (ACA) in the District. Our online marketplace, called DC Health Link (DCHealthLink.com), enables individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance.

The ACA is working in the District of Columbia. Based on a survey of DC Health Link enrollees, 25% of the people who enrolled in individual private health insurance coverage during the most recent open enrollment period were uninsured prior to enrollment; 53% of the people who were determined eligible for Medicaid were uninsured before applying; and 40% of the small businesses enrolled in DC Health Link did not offer health insurance to their employees prior to enrollment through DC Health Link. This new survey by DCHBX confirms the results of three recent national studies showing that the ACA and DC Health Link are having a major impact on reducing the rate of the uninsured in the District of Columbia. These national studies were performed by the U.S. Census Bureau, the Centers for Disease Control and Prevention (CDC), and the Kaiser Family Foundation. The studies conclude that the number of uninsured people in the District has been cut in half since 2013, the year DC Health Link opened for business. These studies also show that the uninsured rate in the District is between 3.7% and 4%, which places DC's uninsured rate as the first, second, or third lowest in the country, depending on the study.

We are proud of our success and appreciate the federal government's regulations giving SBMs flexibility related to SEPs to craft policies that serve local needs and markets. DCHBX has a stakeholder-driven process for SEP policies. Health plans, brokers, consumer and patient advocates, and other members of the DC community participate. The stakeholder-driven policies balance the goal of enabling our customers to access affordable quality private health insurance coverage with the need to ensure that there are cost-effective reasonable processes in place to safeguard against improper use of special enrollment periods. The risk that qualified people would be deterred from enrolling by an over-burdensome process is real. The Department of Health & Human Services (HHS) acknowledged this risk in its recent request for comment in the HHS Notice of Benefit and Payment Parameters for 2018.[1]

DCHBX verifies that a customer seeking a SEP meets applicable criteria either through attestation under penalty of perjury or through review of information/documentation from the customer, the carrier, or our own systems--with the goal of eliminating unnecessary barriers to coverage.

The purpose of this letter is to express our profound disappointment with the utility of this report for the following reasons:

- The characteristics of DC Health Link are too different to be useful in this case study.
- The study is not useful to help improve our current approach and processes because the GAO chose to generalize information instead of providing specific details pertaining to each state.
- Unlike other reports where GAO created plausible fictitious scenarios, here GAO used fictitious cases that are highly unrealistic, manufacturing phony employer documents and phony medical documents. Furthermore, GAO failed to provide evidence or data to support the assumption that consumers are likely to manufacture phony employer documents or phony medical documents.[2]
- GAO's position to oppose self-attestation is contrary to well accepted practices by federally funded programs.
- DCHBX's approach to SEPs and acceptance of self-attestation is consistent with the GAO's Cost-Benefit Approach to fraud control.
- <u>There are no findings and no recommendations specific to DCHBX</u>. Neither the report nor discussions with GAO staff suggested that DCHBX should have processed any case differently than we did.

Unlike other GAO reports and case studies that enabled us to examine our approach and processes with the goal of always looking for ways to improve, this report lacks actionable information.

We appreciate GAO's explicit admission of the report's shortcoming in part by stating, "in some instances we provided *fictitious documents* to the federal and selected state-based marketplaces to support the SEP triggering event and were able to obtain and maintain subsidized health coverage. Our applicant experiences are *not generalizable* to the population of applicants or marketplaces."[3] (Emphasis added.)

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[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61456, 61502-61503 (proposed Sept. 6 2016).

[2] An illuminating and relevant experience is to look at HIPAA and whether there was wide spread fraud related to HIPAA certificates of coverage, which were necessary to access private health insurance when leaving job-based coverage. GAO does not reference any such data.

[3] GAO DRAFT Report at page 13.

Characteristics of DC Health Link Too Different to be Useful in a GAO study

The GAO report focuses on enrollment controls as a means of controlling federal spending on subsidies. The report states,"[b]ecause subsidy costs are contingent on eligibility for coverage, enrollment controls that help ensure only qualified applicants are approved for coverage with subsidies are a key factor in determining federal expenditures under the act."[4]

DCHBX's SEP customer base is: 93% full pay and 7% APTC. Because DC Health Link subsidized enrollment is so different from enrollment in all other SBMs and the federal marketplace, the DC Health Link experience is neither instructive nor informative to other marketplaces.

DC Health Link enrollment demographics and key differences are as follows:

- 35% of currently enrolled private individual marketplace customers are 26 to 34 years old (Table 1).
- Approximately 7% of enrollees currently covered by private health insurance receive Advance Premium Tax Credit (APT), and fewer than 2% are eligible for cost sharing.[5]
- Customers who enrolled through a ***SEP are younger*** than those who enrolled during the last open enrollment (Table 2).
- 81% of SEP enrollees are under the age of 45 (2016), age being a proxy for health (Table 2).

TABLE 1: DC Health Link Individual Marketplace Current Enrollees by Age as of 10/2/2016

AGE GROUP	PERCENT
< 18	9.8%
18-25	5.8%
26-34	35%
35-44	20.3%
45-54	15%
55-64	13.5%
65+	0.6%

Table 2: DC Health Link People by Age Enrolled in Private Individual Health Insurance as of 10/2/2016

Age	3rd Open Enrollment %	2016 SEP %
< 18	8%	10%
18-25	9%	8%
26-34	38%	45%
35-44	19%	18%
45-54	14%	10%
55-64	12%	9%
65+	1%	0%

[4] GAO DRAFT Report at page 1.

[5] This is due to two factors: 1) Young people are less likely to qualify for APTC because of age rating and 2) DC's Medicaid program covers single adults with incomes up to 215% of the federal poverty level (FPL). Most residents who otherwise would qualify for APTC instead qualify for Medicaid coverage.

What the data shows is important for two reasons. First, DC Health Link has a stable and young risk pool and does not have the issues that some markets have with low enrollment of younger people. A mix of younger and older people is important to keep the insurance pool stable. Age is a proxy for health, and if a risk pool only insures older people, premiums would reflect high claims and would be unaffordable for many. Second, DC Health Link's SEP population is younger than the open enrollment population. This means that there is no evidence of systemic abuse of SEPs. In other words, there is no evidence that people are waiting to get sick to enroll in coverage, abusing a SEP. It also means that DCHBX' current process works well, balancing the need to make it easy for all age groups (and especially younger people) to enroll in affordable, quality health insurance with the need to mitigate fraud and abuse.

There is no evidence of systemic abuses of SEPs and DC Health Link's percent of full pay customers compared to federal subsidy eligible customers makes inclusion of DC Health Link in the GAO report of little use.

DCHBX Special Enrollment Period Policy and Process

DCHBX's SEP rules are based on federal law. Where the law allows states to have different standards, DCHBX's Executive Board adopts policies based on recommendations of its Standing Advisory Board, which represents views of health plans, consumer advocates, brokers, small businesses, and others.

Consumers can request a SEP online at DCHealthLink.com or by calling the DC Health Link Contact Center. As acknowledged by GAO repeatedly in its report[6], under federal law, states are permitted to choose when to accept self-attestation[7] and when to request documentation. For SEPs requiring attestation, after attesting to the triggering event and timing for the event, an eligible consumer is allowed to select a health plan for enrollment.

For SEP–triggering events where DCHBX requires additional verification, there is a multi-layer review process. The customer must first request the SEP through the DC Health Link Contact Center. If the customer began the process through his or her online account, the system prompts him/her to contact the DC Health Link Contact Center. There, a customer service representative asks further questions to gather relevant information and requests documentation if applicable.

The DC Health Link Contact Center then refers the request to the DCHBX Member Services team for the first level of review. In this process, a case manager reviews the facts presented and the customer's eligibility and/or enrollment record, including the dates the customer applied for coverage and made plan selections, and/or his/her prior history of seeking assistance, including call history as applicable. The case manager may contact the customer, the insurance carrier, the Medicaid agency, an Assister, a Navigator, or a broker for more information. If the SEP can be verified in this review, the case manager can approve the SEP request. Only after a SEP approval can a customer enroll in coverage or change current coverage. A customer cannot shop for a plan unless and until a SEP is approved.

All denials or cases requiring further review are sent for a second level of review to the SEP Review Committee. This Committee is chaired by DCHBX's Deputy Director of Marketplace Innovation, Policy & Operations and includes senior-level representatives from Plan Management, Member Services, and the

[6] Acknowledged by GAO in the DRAFT Report at pages 2, 7-8, and 22.
[7] Acknowledged by GAO in the DRAFT Report at page 8.

Office of General Counsel. The SEP Review Committee considers the entire record to date and may gather additional information to complete its evaluation. If the SEP can be verified in this review, the SEP request is approved, and the customer may enroll in coverage or change current coverage.

After review by the SEP Review Committee, denial cases are sent for a final third layer of review by the DCHBX General Counsel and/or Executive Director. Following this final review, customers with an approved SEP are permitted to enroll in coverage or change current coverage. Those not approved are sent a denial letter that explains their right to appeal the decision to the DC Office of Administrative Hearings.

DCHBX works closely with the health plans on many SEP cases. This includes performing a close review, including gathering facts on certain types of cases.

GAO's Opposition to Self-Attestation is Unfounded

GAO asserts that self-attestation is ineffective in stopping inappropriate SEP enrollments.[8] This assertion rests on a false premise reflected in GAO's methodology. GAO investigators lied to get SEPs through: They attested under penalty of perjury to facts they knew to be false. GAO investigators have a unique ability to act in a way not representative of the average consumer, such as lying—by attesting summarily to facts under penalty of perjury, when they know those facts are false. Importantly, GAO did not provide data from the ACA or other federal programs to support the assumption that a significant portion of people perjure themselves to access federal funds.

The GAO position is contrary to a well-established and accepted practice in federal government programs.

The Accepted Use of Self-Attestation in Federal Programs

Other federal programs recognize that consumers generally do not lie under penalty of perjury, and thus have long allowed self-attestation.

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[9] 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.[10] Notably, if the applicant was determined eligible to receive only unsubsidized student financial assistance, his/her form is specifically excluded from verification.[11]

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[8] GAO DRAFT Report at page 18-19.
stating, "[h[owever, relying on self-attestation without verifying documents submitted to support a SEP triggering even could allow actual applicants to obtain subsidized coverage they would otherwise not qualify for."
[9] *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).
[10] 34 C.F.R. §668.54(a).
[11] 34 C.F.R. §668.54(b).

Not only do SEP self-attestations reflect a well-accepted practice of self-attestation in federal programs. SEPs have their origin in the Health Insurance Portability and Accountability Act (HIPAA)[12]. The long-established SEP provisions under HIPAA do not include mandatory verification processes and permit the acceptance of self-attestation.[13] State-based marketplaces should not be held to higher standards than those that apply to the federal government.

DCHBX's Approach Is Consistent with the GAO's Cost-Benefit Approach to Fraud Control

DCHBX's approach to SEP verification is consistent with GAO's accepted practices. In its "Framework for Managing Fraud Risks in Federal Programs",[14] which GAO specifically recommends to the federal marketplace, GAO identified guiding principles with the overarching goal of developing a "strategic, risk-based approach to managing fraud risks."[15] The framework calls on managers to take steps such as determining the risk profile of the program[16] and using the characteristics of the program, along with risk tolerance, to conduct a cost-benefit analysis[17] of any proposed fraud control activity. GAO instructs that, as with any cost-benefit analysis, "managers may decide not to implement certain control activities for which the estimated benefits do not exceed the costs."[18] This analysis is not simply monetary; non-monetary factors may be considered when deciding whether to implement a control activity.[19]

DCHBX has reviewed the characteristics of the marketplace, consistent with the principles embraced in GAO's Framework, and assessed risk to develop appropriate verification procedures. Factors considered in the risk assessment included the fact that customers may not proceed with an application through DCHealthLink.com or our Contact Center without successfully passing ID proofing.[20] There is no conditional eligibility for people whose identity cannot be verified. People must come in person for ID proofing by HBX staff. Further, because over 93% of our customers pay full price for coverage, in most cases, federal dollars are not at risk. Also, the age of the SEP population shows no systemic abuse of SEPs.

We balance this low risk profile against both the financial and non-financial costs of an overly burdensome documentation requirement for all SEP requests. We consider the impact on the marketplace if healthy SEP eligible customers forgo enrolling because of the hurdles and burdens imposed. We also consider our own resources and authority when constructing a verification plan.

DCHBX has concluded it is neither an efficient use of resources to review and verify, nor worth the burden on the customer, to require documentation in many SEP scenarios such as recent marriage, birth, or move to the District. Instead, DCHBX permits customers to attest to these facts under penalty of perjury. For other SEPs, such as a marketplace or carrier error, additional information or verification is required. When additional information is required, DCHBX recognizes that third parties, such as

[12] 42 U.S.C §300gg-3(f) (including loss of other coverage or Medicaid, marriage, birth, or adoption or placement for adoption).
[13] 45 C.F.R. §146.117..
[14] GAO-15-593SP (July 2015).
[15] Id. at 2.
[16] Id. at 11.
[17] Id. at 21.
[18] Id.
[19] Id.
[20] Very few people use paper applications. Federal guidance exempts paper applications from ID proofing.

medical providers and employers, may face legal constraints, such as limitations under the HIPAA Privacy Rule, which would prevent them from responding to DCHBX requests to validate documents that customers submit.

Ultimately, any residual risk produced -- although none has been definitively demonstrated by the GAO, the insurance carriers, or DCHBX internal efforts -- is within appropriate risk tolerance. Also, as a health insurance marketplace supported by an assessment on health carriers which is passed on to consumers, there is no evidenced-based case to justify the cost of an extensive verification framework.

Conclusion

Thank you to the professional GAO staff who worked with the DCHBX staff. DCHBX welcomes fact-based reviews and concrete feedback to help improve our processes. Unfortunately, this report falls short on both fronts.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority