



April 18, 2014

Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-9949-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond CMS-9949-P.

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority appreciates your consideration of our comments below. If the proposed rules are adopted without changes, the new policy will create a significant adverse impact on DC Health Link – the District's on-line marketplace.

SHOP Open Enrollment §155.725(c)

HHS has proposed to amend 45 CFR §155.725(c)(1) to align the employer election period in SHOP with the individual market exchange open enrollment period. Here is how we read the proposed rule to apply:

- New and renewing employers that do not meet minimum participation and contribution rates cannot begin the employer election process prior to November 15<sup>th</sup>.
- New and renewing employers that meet minimum participation and contribution rates can enroll/renew throughout the year.
- The proposed rule does not change how the District of Columbia's hybrid local merged market is treated for purposes of open enrollment.
- Congress as an employer (although meeting minimum participation and contribution rules of the District of Columbia) would no longer be allowed to align their employee open enrollment with current FEHB enrollment and instead would have to use the open enrollment applicable to individuals and small businesses that do not meet state participation and contribution standards.

**Open Enrollment for Small Businesses that do not meet minimum participation and contribution standards**

We strongly oppose any limitation that prevents a state, including the District of Columbia, from allowing employers to begin their election process prior to November 15<sup>th</sup>. The proposed timeline would not provide affected employers and their employees with adequate time to complete the enrollment process to effectuate coverage by January 1. The proposed timeline would also unduly strain our limited staff resources, forcing staff to run two open enrollments concurrently for very different market segments – with different coverage options and different on-line processes.



The DC Health Link SHOP and Individual Marketplace have been open for business since October 1, 2013. We have enrolled District of Columbia businesses as well as Congressional staff and members. We also enrolled thousands of residents. Our total enrollment is over 43,000. In part, we have been successful because we staffed each market segment we serve – small businesses, individuals, and Congress. Our staff enrolled Congress and small businesses and were then shifted to help with individual enrollment.

We urge HHS to not limit state flexibility. The current regulations for SHOP open enrollment set forth in 45 CFR 155.725(c) should be retained. This will ensure that a state's SHOP open enrollment period fits the needs of the insurance market in the state, works for new and renewing small businesses that do not meet minimum participation and contribution rates, and ensures that limited resources of the Marketplace are not further stretched.

### **Merged market**

The District of Columbia has a hybrid merged individual and small group market for local rating purposes only. The merged risk pool does not change how carriers choose to offer plans in the individual or small group market, allows SHOP to have year round enrollment, and allows quarterly changes in rates for new business in SHOP. We assume that the proposed rules would not impact our hybrid merged market.

We strongly oppose any interpretation of the proposed rule that would have the effect of moving the District's small group employers to a one-time-a-year open enrollment period.

### **Congressional Enrollment**

It is our understanding the proposed rule is intended to treat Congress like an employer that does not meet participation and contribution standards. Consequently, they would no longer be allowed to align their employee open enrollment with current FEHB enrollment and instead would have to use the open enrollment applicable to individuals and small businesses that do not meet state participation and contribution standards.

We strongly oppose this proposed change. DC Health Link has been designated by OPM as the Marketplace that serves over 12,000 congressional staff and members. For the 2014 plan year, Congress was able to enroll in plans during the same time period as FEHB open enrollment period (November 11 to December 9, 2013), which allowed this population to make plan selections at the same time during the year as other Congressional staff that continue to receive coverage through FEHB, and as they make other benefit elections. The employer had to create accounts, provide employee census, and prepare for a new system prior to November 11. Open enrollment for Congress must be allowed to continue to coincide with FEHB open enrollment so that Members of Congress and their designated staff can make all benefit elections at one-time during the year. This is essential, as OPM continues to administer retirement and other benefits for this population. We strongly oppose any proposed new rule that would require congressional open enrollment to be conducted during a period that is not identical to FEHB.

### **Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards §§155.210, 155.215 and 155.225**

We urge for additional flexibility.

1. §155.210(e)(6), 155.215(g) and 155.225(f) would require Navigators, non-Navigator assisters, and CACs to provide consumers with a notification of their functions and responsibilities and obtain written authorization. We ask that Navigators have the flexibility to provide an authorization in electronic form

to consumers that we can include in the current limited authorization consumers are agreeing to electronically. This would reduce the burden of this requirement related to printing and retention costs associated with paper forms, and to conform to Exchange enrollment systems which rely on electronic disclosures for many consumers. We urge that any specified language be short and clear. In addition, marketplaces should be permitted to retain these disclosures on behalf of Navigators. Currently, Navigators in the Marketplace are not required to retain records, as Navigator transactions are preserved in our electronic enrollment system. Consequently, this requirement would create a new retention requirement for Navigators, where the Authority can more effectively carry out this action on their behalf. This requested flexibility would ensure that records are retained for an adequate period of time while reducing the burden placed on Navigators.

2. §155.225(d) would require CACs to undergo annual recertification to continue in the CAC program. The Authority currently requires CACs to undergo training throughout the year to ensure they are trained on updates that occur after they have passed the initial training requirements. As CACs are already receiving training from the Authority on a periodic basis, we believe that an annual recertification is not necessary in all state marketplaces to keep CACs up to date with current Marketplace requirements. We ask that state marketplaces be provided with flexibility to determine the frequency with which CACs must complete recertification training and be recertified, so that state marketplaces can ensure that training is provided when necessary but also to prevent unnecessary duplication of training.

#### Verification of Eligibility for Minimum Essential Coverage Other Than Through an Eligible Employer-Sponsored Plan §155.320(d)

HHS is proposing to eliminate the option for state marketplaces to rely on HHS to conduct verifications of enrollment under §155.320(d) in eligible employer-sponsored health plans for purposes of determining eligibility for advance payments of the premium tax credit. Only a nationwide resource is sufficiently comprehensive to address these data needs.

As such, we urge HHS to maintain this option or to work to make additional electronic data sources available to state marketplaces. This will better enable states to conduct comprehensive verification. While states are using data sources available to them at the state level, access to more comprehensive federal data sources would allow for a more robust process.

#### Notices -- Initial and Annual Open Enrollment §155.410(d)

We support the proposal to provide the notice of annual open enrollment and redetermination no earlier than October 1 and no later than November 15, which would provide state marketplaces with additional flexibility to determine when to provide this notice to consumers.

#### Options for Conducting Eligibility Determinations for Exemptions §155.625

HHS proposes to eliminate the option for state marketplaces to adopt eligibility determinations for exemptions made by HHS as currently set forth in §155.625. We strongly oppose this proposal because of the undue burden, cost, and time and resource pressure it places on state marketplaces.

This proposal alters the scope of responsibility that state marketplaces are required to shoulder after the marketplaces have already built IT systems and allocated funding for systems development. State marketplaces

have relied on the availability of the federal process to address exemption appeals which would permit states to provide access to exemption applications, then transmit to HHS for a determination, which the state would then notify the consumer of the determination.

In reliance on the availability of this process, resources that would have been allocated to building this functionality have been reallocated to address high priority issues. The District of Columbia, for example, did not include this functionality in the needs assessment in its establishment grant application. This proposed change would place an unexpected burden on state marketplaces, and if finalized states would have a limited time to make significant system changes. So if the proposed change to §155.625 were finalized, the District would be left with no choice other than an almost completely paper-based and manual exemption eligibility determination process, at least for 2015 and potentially beyond. Systems changes for this would cost millions.

We believe that the process as currently set forth in §155.625 could be modified to address the administrative concerns raised by HHS. For example, with regards to the concern that HHS does not have access to the cost of the lowest-cost bronze, this issue could be resolved by asking that consumer to include this information with the appeal request, which state marketplaces could provide to consumers subsequent to a completed application for insurance affordability programs.

In light of these concerns, we ask that HHS retain the current process for state marketplaces to utilize for the foreseeable future. If HHS proceeds with eliminating this option, at minimum the District would need additional time to develop our own exceptions processes. We would ask that state marketplaces be given until at least November 2015 to develop these processes and that further grant funding be allocated for this purpose.

We thank you for considering our comments and look forward to continuing to work with the federal government on implementation of the Affordable Care Act. We are available to discuss our comments and would be happy to answer any questions.

Sincerely,



Mila Kofman  
Executive Director  
DC Health Benefit Exchange Authority