



October 6, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9934-P
P.O. 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 - CMS-9934-P

To Whom It May Concern:

The District of Columbia (District; DC) Health Benefit Exchange Authority (DCHBX) appreciates your consideration of our comments on the above-cited Notice of Proposed Rulemaking (NPRM). DCHBX is an independent instrumentality (private-public 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.

Summary

The ACA is working in the District of Columbia. Based on a survey of DC Health Link enrollees, we know that 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 DC Health Link is 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 rate of the uninsured in the District is between 3.7% - 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 appreciative of CMS for implementing the ACA in regulations that give SBMs flexibility to serve local needs. Many proposals in the NPRM continue this flexibility for SBMs, and these we support strongly. A few proposals have the opposite effect, tending to impede SBMs, and these we oppose. We urge CMS to continue supporting and strengthening SBMs.

Highlights – Proposals that Strengthen Marketplaces

DCHBX strongly supports the Centers for Medicare & Medicaid Services' (CMS) continued work to



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strengthen marketplaces and the ACA. The following list highlights proposals in the NPRM that we support because they will strengthen marketplaces and increase our flexibility to innovate and meet local needs. More detailed comments on these and other NPRM proposals follow.

- § 155.230—to make electronic notices the default option for SHOP marketplaces;
- § 155.330—to provide flexibility for marketplaces in conducting eligibility redeterminations during a benefit year, including recalculating premium subsidies;
- § 155.420—to codify the special enrollment periods proposed at (d)(8)(ii); (d)(10); (d)(11); (d)(12); and (d)(13), and the corresponding amendments to §155.725(j);
- § 155.430—to explicitly authorize marketplace oversight of rescissions; and
- § 155.505, § 155.555, and § 155.740—to permit marketplace flexibility in appeals processing.

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

DCHBX strongly supports the proposal to codify the special enrollment periods (SEP) at§155.420(d)(8);(d)(10); (d)(11); (d)(12); and (d)(13). The proposal to expand the SEP for Native Americans to their dependents makes that SEP consistent with all other SEPs, which are available to both the eligible individuals and dependents. The proposal to codify a SEP for victims of domestic violence and spousal abandonment meets a serious need of vulnerable populations. To meet this need, DCHBX created an exceptional circumstance SEP in 2014, and we support the proposal to codify this SEP in federal regulations.

CMS has also requested information on allegations that customers are misusing SEPs. DCHBX works to make the enrollment process as efficient as possible, so people can stay insured. DCHBX works closely with the carriers offering coverage through DCHBX. This includes performing a close review on a case-by-case basis of SEP requests. We do not have evidence from insurers that there are systemic problems with SEPs. In fact, in reviewing 2016 enrollment in DC, the special enrollment period population is actually younger than the population that enrolled during the open enrollment period.

Age	Open Enrollment%	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%
TOTAL	100%	100%

Because age is a proxy for health and utilization of medical care, we use age of enrollees as an indicator of potential systemic problems. We monitor this data closely and report it to our Board regularly.

CMS has requested comment on the need for additional verification requirements for special circumstances SEPs. Additional verification requirements will deter qualified people from enrolling. We already see this with our current document verification requests in cases where people forget to provide documentation timely, provide evidence too late and lose their opportunity to enroll. Additional verification requirements will also require new resources. When we first deployed the on-line marketplace, we required documentation and manually processed all SEPS. The documentation

verifications yielded nearly no positive results and created huge backlogs, delaying people's coverage. We oppose a policy that would require SBMs to implement additional verifications and further stretch limited resources.

CMS also issued guidance on a CMS Pilot Program to evaluate a pre-enrollment verification process. DCHBX believes that the outcome from this pilot project should be restricted to policy on the FFM and not be used to restrict SBM policies or processes. Each SBM has its own unique needs, based on its location, the population it serves, applicable state and local laws, and the structure of the marketplace itself. The Pilot Program may provide key lessons, but SBMs should have flexibility to apply those lessons as appropriate to local budgets, populations, market conditions, and legal requirements. DCHBX strongly urges CMS to maintain state flexibility in the administration of special enrollment periods.

QHP Issuer Participation Standards (45 C.F.R. § 156.200)

The NPRM appears to consider eliminating the online enrollment function for FF-SHOP.

In DC to-date, small businesses covering more than 24,000 employees (and their family members) have enrolled through DC's SHOP. In a survey of small businesses covered through DC Health Link, 40% reported that prior to enrolling through DC Health Link, they did not offer health insurance to employees. As intended by the ACA, the SHOP offers small businesses and their employees a series of benefits never before available:

- **Choice:** For the first time, small businesses can offer their employees a choice of coverage from more than just one insurer.
- **Transparency and Competition:** For the first time, small businesses can get complete, unbiased information on all prices and policies.
- **Purchasing Power:** For the first time, small businesses have the purchasing power that once only large employers had.
- **Simplicity:** The on-line marketplace enrollment is simple.

Online enrollment is a cornerstone of the SHOP design as envisioned by the ACA, because online enrollment enables a transparent, competitive marketplace, unimpeded consumer choice, and purchasing power. Eliminating or altering online enrollment and replacing it with alternatives such as direct enrollment by issuers would undermine the SHOP program and reduce these key benefits. We recognize the challenges that the FFM has had and we also recognize the flexibility that SBMs need. FFM SHOP should be strengthened so states not able to have their own robust competitive SHOP could rely on the FFM SHOP. Direct enrollment in the FFM SHOP is inconsistent with choice, transparency and competition, purchasing power, and simplicity. The SHOP enrollment process enables employers to compare all SHOP plans impartially without being steered to one plan or one carrier, promoting real competition among health plans. The regulatory proposal would eliminate employee choice and the competitive benefits associated with it.

DCHBX strongly urges CMS to reject this proposal and continue to ensure that SHOP grows and thrives, as envisioned by the ACA.

Consumer Assistance (45 C.F.R. § 155.205)

DCHBX is subject to language access requirements under federal marketplace regulations at § 155.205, under the new nondiscrimination regulations under section 1557 of the ACA, and under District of Columbia law. DCHBX urges CMS to clarify that an entity which meets the language access requirements under the section 1557 regulations is deemed to meet the language access requirements under §

155.205. This clarification would reduce the confusion and burden of complying with overlapping requirements.

Levels of Coverage (45 C.F.R. § 156.140)

DCHBX supports the proposal to permit QHP issuers to offer more robust bronze level plans. This flexibility will enable QHP issuers to innovate with benefit enhancements that make bronze plans more attractive to customers. DCHBX supports the proposed list of major services that issuers may elect to cover and pay for before the deductible, so long as they are provided in compliance with mental health parity. DCHBX is concerned that people with mental health and substance abuse needs would be treated differently than people with other types of medical needs. CMS should provide further clarification to ensure full parity.

Enrollment of Qualified Individuals into QHPs (45 C.F.R. § 155.400)

DCHBX supports the proposal to retain state flexibility on binder payments. In addition, DCHBX supports the proposal to clarify § 155.400(e) so that a binder payment would not be required when a current customer switches to any plan with the same issuer.

Enrollment Periods under SHOP (45 C.F.R. § 155.725)

DCHBX supports the proposed changes to § 155.725(g). Prior to the proposed change, incompatible deadlines made it difficult for the marketplace and employers to meet enrollment timeframes and waiting period rules. We support CMS' recognition of this tension and proposed rule to resolve it.

Web Brokers/Issuer Direct Enrollment in QHPs (45 C.F.R. § 155.220 and §156.265)

We appreciate efforts by CMS to expand enrollment opportunities and we concur with the policy recommendations and issues raised in Covered California's comments related to Web-based entities (WBE), specifically recommendations to:

- Strategically assess WBEs in the context of the broader marketing and member retention effort including impact to marketing investments, additional sales distribution costs for QHPs, potential to create sales channel conflict, and plan selection and effectuation rates;
- Assess the upfront and ongoing IT and administrative costs prior to implementation;
- The critical importance of choice architecture -- plan choice decision support elements;
- Appropriate staffing to support WBE post enrollment activities;
- Enforce the requirement that WBEs fairly display the scope of products available; and
- Validation of WBE/QHPs' plan choice decision support service.

We also recommend that CMS develop a clear and transparent oversight plan that specifically looks at WBE enrollments into QHP and non-QHP coverage to prevent the types of problems that would result when healthy people are steered into short-term policies. Without appropriate oversight, if steering occurs, the risk pools could be destabilized. Importantly, consumers may lose their opportunity to enroll in comprehensive high quality health insurance if they are steered to buy short term policies (these are underwritten), nor do these policies have the same protections.

Also, to be clear, DCHBX opposes direct enrollment by WBEs and opposes the collection of financial information by WBEs and insurers. Eligibility for APTC and CSR relies on personal financial information. Our community partners and DCHBX brokers in the Washington metropolitan area are best positioned to assist DC residents and businesses with their health coverage needs. In addition to extensive training and continued training, our navigators and assisters go through an FBI and local criminal background

check. We are not confident that the same level of scrutiny and oversight by CMS would exist for WBEs especially given many competing priorities and limited resources.

Furthermore, when DCHBX looked at best ways to provide customer assistance and maximize enrollment opportunities, DCHBX staff met with a large web-based broker. Ultimately, the web-based broker was not a fit. The web-based broker could not provide any information related to issue resolution, complaints, or any quality elements related to customer service. Upon discussions with our local brokers, DCHBX staff learned that in fact, the quality of service would not meet our current standards applicable, for example, to our contact center. The local broker community in the District provides exceptional service to DCHBX customers and works closely with DCHBX staff on issue resolution. DCHBX's success in part is due to the quality of service provided by DCHBX staff, DCHBX assisters and navigators, business partners and, importantly, the local broker community. Thus, we reiterate our opposition to direct enrollment by WBEs.

DCHBX also opposes direct enrollment by issuers. With the purchasing power of thousands, DCHBX advocates for our customers to get the best possible premiums and products. We provide the insurance regulators with independent actuarial analysis, advocating for the lowest possible premiums for our customers. We also fight for our customers when they have problems with their insurer. In 2017, DCHBX small business customers have access to 151 different QHPs from four large insurers and individual marketplace customers have access to 20 different QHPs from two large insurers. We have employer and employee choice – enabling small businesses to select a metal level and allowing employees a choice of issuers and plans in the metal level. The full implementation of the ACA's SHOP in the District means that finally small businesses have the purchasing power of large employers. We have non-standardized and standardized plans for individual customers, all-plan doctor directories for individual and small group customers, and search and filter rules engines informed by customer experience and feedback. We also have DCHBX Plan Match powered by CONSUMER'S Checkbook, using a sophisticated and seasoned algorithm that enables our customers to compare plans based on total out-of-pocket costs, taking into consideration expected health care needs. This year, we have added a formulary tool to DCHBX Plan Match that allows DCHBX customers purchasing private health insurance to see which plans cover their prescribed medications and what the cost sharing is for those medications. A customer can enter up to 10 prescriptions and see a list of health insurance plans covering the medications and how each medication is covered.

To allow QHP issuers and WBEs to directly enroll contradicts the principles behind having ACA marketplaces. Marketplaces are a place where consumers have access to unbiased information. Marketplaces do not have the financial incentives web-based brokers and issuers have when providing information to consumers. We do not have a financial interest in which plan a consumer selects. This impartiality enables ACA marketplaces to provide unbiased information to enable customers to make the best decisions.

If regulations expand the role of direct enrollment, successful implementation of ACA marketplaces in states would be in jeopardy. We have created real health insurance competition where issuers compete for business and where consumers have unbiased necessary information to make informed decisions.

Marketplace Innovation

CMS has requested comment on ways to help marketplaces innovate and make health coverage more accessible and affordable for consumers. DCHBX encourages CMS to explore options that would provide marketplaces flexibility to offer products such as vision insurance, disability and other products that

small businesses want as part of their full benefits package, as well as products that are hard to access in the individual market compared to the group market. Additional, CMS should look for ways to improve affordability.

Conclusion

DCHBX supports state-based solutions and flexibility for SBMs. We appreciate the strong partnership we have with CMS and other federal agencies. Thank you for considering our comments on proposed regulations.

Sincerely,

A handwritten signature in black ink, appearing to be 'Mila Kofman', with a long horizontal flourish extending to the right.

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority