



December 29, 2020

Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attn: CMS-9914-P  
P.O. 8010  
Baltimore, MD 21244-1810

**Re: HHS Notice of Benefit and Payment Parameters for 2022 – CMS-9914-P**

To Whom It May Concern:

The District of Columbia 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 (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.

**Direct Enrollment and Web Brokers (45 C.F.R. §§155.220 and 155.221)**

The Administration's interpretation of the Affordable Care Act's (ACA) exchange marketplace requirements is not reasonable, the Administration does not have the authority to amend the ACA without Congress, and the Administration does not have the authority to transfer essential governmental functions to web-based brokers and insurance carriers. The Administration's proposals put consumers at risk and endanger stable ACA insurance markets. HBX strongly opposes these proposals and requests that the Centers for Medicare & Medicaid Services (CMS) withdraw them.

The proposed changes are not a reasonable interpretation of the statute. The ACA establishes standards for exchanges to facilitate enrollment into qualified health plans (QHPs). The Administration proposes to interpret these provisions to include returning to pre-ACA shopping and enrollment approaches with direct enrollment and web-based brokers, functionally equivalent to eliminating public ACA exchanges. It is not a reasonable interpretation to return shopping and enrollment to pre-ACA days. It is also not a reasonable interpretation to get rid of ACA public exchanges. The Administration's proposed approach is also contrary to the ACA's no wrong door policy for Medicaid and subsidy programs. The current proposal ignores this



1225 Eye Street NW, 4th Floor, Washington, DC 20005

requirement and consequently is unreasonable. Furthermore, returning to pre-ACA markets and the privatization of ACA's public marketplace exchange responsibilities is functionally equivalent to amending the ACA without Congress, which the Administration does not have the authority to do. In addition, the Administration does not have authority to delegate essential government functions currently performed by public marketplace exchanges as proposed. The proposal should be withdrawn.

*Consumers are better served through ACA exchange marketplaces*

The Administration asserts that direct enrollment by insurers will benefit consumers through an enhanced and better shopping experience. However, the Administration does not offer any evidence to support the assertion. Additionally, while the current Administration claims to believe in transparency and consumer empowerment, it proposes to eviscerate public marketplace exchanges that provide objective and neutral information to insurance consumers – information that is not influenced through commissions or other payments from carriers. In fact, the Administration's proposal would deprive consumers of unbiased decision support tools and would allow insurance consumers to be steered to carriers and products. The privatization of marketplaces through the creation of Direct Enrollment Marketplaces or through web-based brokers is not in the interest of consumers.

In the past, limited direct enrollment was allowed mostly in cases where technology did not work. Now the federal marketplace and state-based marketplaces have technology that works well. Exchange marketplaces provide comprehensive and unbiased information and foster competition based on price and quality. For example, DC Health Link empowers customers to make informed decisions through tools like Plan Match powered by Consumers 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. In addition, we provide all-plan doctor directories and prescription medication formulary instant look up tools, as well as search and filter rules engines informed by customer experience and feedback. In fact, we rank number one among all state-based marketplaces and the federal marketplace for our consumer decision support tools.<sup>1</sup> In addition to on-line tools, our assisters and certified brokers (with appointments with all carriers to prevent steering – a standard developed by our Producer Advisory Committee and adopted by our Executive Board) assist customers who prefer in-person shopping and enrollment experience over on-line shopping.

ACA marketplace exchanges in states provide consumers with access to unbiased and complete information. Marketplaces do not have the financial incentives web brokers and issuers have when providing information to consumers. This impartiality enables ACA marketplaces to provide unbiased information to enable customers to make informed decisions.

*Direct Enrollment and Web-based Broker approach opens door to fraud and abuse*

Bad actors already create websites that mimic public marketplaces. They sell non-ACA compliant products to unsuspecting consumers, causing some to miss annual open enrollment,

---

<sup>1</sup> DC Health Link ranks number 1 in 2017 and 2018. See "2018 Health Insurance Exchanges," October 2018, Council for Affordable Health Coverage. There was no report card for 2019.

and exposing consumers to huge financial and medical risk for unpaid medical bills.<sup>2</sup> CMS in fact has published alerts to help consumers to protect themselves.<sup>3</sup> In addition, the Government Accountability Office confirms that unscrupulous agents and brokers provide inaccurate or misleading information to consumers to encourage enrollment in junk insurance.<sup>4</sup>

The Administration's proposal would make the current problem worse. One, without a public exchange shopping and enrollment website, there is no simple way as there is now for insurance consumers to differentiate between a legitimate entity and one that is a fraud. Second, allowing the sale of non-ACA compliant plans puts consumers at risk of being steered into junk insurance. We recommend that CMS look for ways to address current market failures, e.g., fraud and abuse, instead of adopting policies that will open the door to more fraud and abuse.

We also are concerned about privacy. Consumers will be at increased risk of having their sensitive personally identifiable information (PII) mishandled or misused by a direct enrollment entity. In the proposed Direct Enrollment Marketplace model, consumers would have no choice but to enroll through private entities and would be forced to share sensitive PII, such as social security numbers, tax and financial information to apply for advance premium tax credits, and immigration documents for meeting the lawful presence eligibility requirement. While direct enrollment entities are subject to section 45 C.F.R. §155.260, there is no existing robust federal regulatory framework and oversight. Even if CMS were to propose to hold direct enrollment entities to the same oversight standards that apply to ACA marketplaces, that would be insufficient since ACA marketplaces are also governmental or quasi-governmental entities subject to significant local and state oversight, audits, and accountability. These concerns are multiplied by the fact that downstream entities beyond the Direct Enrollment Marketplace, which CMS does not propose to directly oversee, will also have access to consumers' personal information including PII.

HBX strongly opposes the proposals and asks that CMS withdraw them.

### **Direct Enrollment Entities Language Access – §155.205(c)**

The Administration is proposing a year-long exemption for direct enrollment entities from current law that requires language access. HBX strongly opposes this exemption.

Currently, covered entities are required to provide website translations under 45 C.F.R. §155.205 if 10% of the population of the state speaks the same language that is not English. The proposal to exempt entities from this requirement would deny consumers access to information about health insurance options and enrollment and prevent consumers from obtaining health insurance coverage, obtaining advance premium tax credits or cost-sharing reductions to make private coverage more affordable, in violation of section 1557 of the ACA. This proposal is blatantly discriminatory and impermissibly targets people based on the legally protected trait of national

---

<sup>2</sup> See e.g. "California Takes Down 10 Fake Obamacare Websites", Reuters, November 14, 2013, available at <https://cn.reuters.com/article/instant-article/idUSBRE9AD17K20131114>.

<sup>3</sup> See <https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/>

<sup>4</sup> "Private Health Coverage: Results of Covert Testing for Selected Offerings," Government Accountability Office, August 24, 2020, page 9. Available at <https://www.gao.gov/assets/710/708967.pdf>

origin. HBX strongly opposes this proposal as discriminatory and contrary to law and asks that CMS withdraw it.

### **1332 Waivers (31 CFR Part 33 and 45 CFR Part 155)**

HBX strongly opposes the Administration's proposal to incorporate by reference the 2018 "guidance" on Section 1332 of the ACA into a regulation. The Administration's policy harms consumers and contradicts the statute. Furthermore, using a reference rather than crafting concrete regulatory language circumvents the intent of the APA. HBX continues to oppose the ongoing effort by the Administration to undo the ACA and attempt to turn back the clock to pre-ACA days of underwriting and discrimination.

Section 1332 of the ACA permits waivers of certain statutory requirements within statutory guardrails. The 1332 waiver's statutory guardrails require that waivers cover at least as many people, with coverage at least as comprehensive and affordable as would be the case without the waiver, without increasing the federal deficit. In 2018, the Administration attempted to undercut these statutory requirements in several ways. The Administration issued "guidance" encouraging states to submit waiver proposals that would weaken protections for people with preexisting conditions, cut financial assistance for older people and consumers with low incomes, and increase out-of-pocket costs, suggesting that such waivers might be approvable under the new guidance.

HBX submitted comments in opposition to the 2018 "guidance" detailing how the Administration's waiver guidance misinterprets and contradicts the statutory guardrails for 1332 waivers. For example, the Administration asserted that a state can meet these guardrails by showing that residents will have access to affordable and comprehensive coverage. By interpreting "provide coverage" as merely access to coverage as opposed to actual enrollment, the Administration's interpretation conflicts with the statute. The full comment letter detailing the harm to consumers and contravention to statute is included in Appendix A.

Furthermore, the Administration is using a highly unusual process. The 2018 "guidance" was not actual rule making. There was no proposed or final regulation. Building on a highly unusual approach, the Administration now seeks to finalize a regulation that has no substantive language but instead references 2018 non-regulatory information published in the Federal Register. This attempt at rule making without outlining actual proposed standards to be in a rule is contrary to the intent of the APA.

We strongly oppose this proposal because it is bad public policy and is beyond CMS's discretion. We ask CMS not to finalize this proposal.

### **Annual Reporting of State-Required Benefits (45 C.F.R. §156.111)**

HBX continues to oppose the new reporting requirement and asks that CMS not implement it. CMS stated in the preamble that it plans to require states to submit the first annual report, identifying state mandated benefits and identifying which mandates require state offsets under federal law, on July 1, 2021 and the second report on July 1, 2022. CMS has failed to support the need for this new burdensome state reporting. See a detailed discussion in HBX March 2, 2020

comment letter on the 2021 Proposed Notice of Benefit and Payment Parameters included in Appendix A.

HBX also opposes the reporting deadlines established by CMS as unreasonable in light of the COVID-19 pandemic. States are focusing limited resources and addressing issues related to the COVID-19 public health emergency. Taking on the new burdensome reporting in the middle of a national public health emergency will mean that states will have to divert limited resources away from helping businesses and residents with issues related to COVID-19. All of us should focus limited resources on reducing the spread of COVID-19 and ensuring that residents have access to healthcare coverage. The Administration should not require states to divert limited resources away from COVID-19 focus. HBX asks CMS to eliminate this burdensome requirement, or at a minimum delay reporting until 2023, assuming the end of the public health emergency in 2021 and economic recovery in 2022. We consider it bad public policy to divert any resources from COVID-19 to address a hypothetical problem that the proposal purports to address.

### **Special Enrollment Periods (45 C.F.R. §155.420(f)) – SEP Verification**

HBX strongly opposes the proposal to require exchanges to verify eligibility for at least 75 percent of special enrollment period (SEP) enrollments. This proposal is contrary to law, will deter enrollment, particularly of healthy individuals, and impose an unfunded mandate on states.

The proposal is based on an unsupported assertion that SEPs were being abused by enrollees resulting in adverse selection. CMS does not provide data supporting abuse of SEPs. CMS also fails to provide data supporting the assertion that abuse of SEPs resulted in adverse selection. The proposed rule is arbitrary and capricious because it lacks a discussion of the relevant data reviewed by CMS in making the proposal and a satisfactory explanation for the proposal including a rational connection between the facts found and the proposal.<sup>5</sup>

HBX has consistently monitored SEP enrollment patterns and we have not seen evidence of abuse. We also coordinate closely with our carrier partners, who have not reported patterns of abuse based on claims information. In fact, in reviewing 2019<sup>6</sup> enrollment, the special enrollment period population was younger than the population that enrolled during the open enrollment period. Age is a proxy for health care usage.

---

<sup>5</sup> *Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 43 (1983).

<sup>6</sup> We cite 2019 data because the 2020 enrollment data is an outlier as it was affected by the COVID-19 pandemic and associated disruptions to enrollee life circumstances.

Age	Open Enrollment %	SEP %
< 18	10%	10%
18-25	5%	7%
26-34	34%	40%
35-44	22%	22%
45-54	15%	12%
55-64	13%	9%
65+	1%	1%
<b>TOTAL</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. Based on prior experience, the proposed requirement for verifying 75 percent of SEP enrollments would drain exchange resources without any demonstrated benefit. And, its impact would be significantly negative as the imposition of additional hurdles would deter younger, healthier enrollees from completing enrollment – which would negatively affect the risk pool in DC.

HBX appreciates the preamble language on state flexibility and that CMS recognizes the importance of marketplaces reflecting the needs of their consumers and market. HBX strongly supports state flexibility and requests that CMS maintain the current flexibility of state-based marketplace SEP verifications. HBX also asks CMS not to finalize the SEP proposal.

#### **Special Enrollment Periods (45 C.F.R. §155.420(a)(4)(ii) & (iii)) – Metal Level Restrictions**

CMS proposes to allow individuals and their dependents to change to a plan in a different metal level based on the loss of APTC or CSR. While HBX supports CMS relaxing some of the metal level restrictions they previously imposed, we continue to oppose all restrictions on changing metal levels. Consistent with our comments on the Market Stabilization Rule, the 2019 Notice of Benefit and Payment Parameters (NBPP), and the 2021 NBPP, we believe these restrictions are arbitrary and capricious and inconsistent with the statutory language of the ACA. HBX comments on the 2019 and 2021 NBPP are included in Appendix A. The statute requires marketplace SEPs to be consistent with existing SEPs under HIPAA and metal level restrictions are contrary to longstanding HIPAA SEP rights.<sup>7</sup> HIPAA requires that SEP-eligible individuals have the same election rights as regular enrollees, including the right to select from any plan available. We ask CMS to allow a change to any plan in any metal level.

#### **Special Enrollment Periods (45 C.F.R. §155.420(d)(1)(v)) – COBRA Coverage**

CMS proposes to create a new SEP related to COBRA coverage. Specifically, CMS proposes to designate the cessation of employer contributions for COBRA continuation coverage as a triggering event for SEP eligibility in the individual market. CMS also requested comments on

---

<sup>7</sup> Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (Aug. 21, 1996), Section 2701(f).

whether this proposed SEP should be expanded to situations where an employer reduces, but does not eliminate, the employer COBRA contribution.

HBX supports a broader policy and urges CMS to establish a SEP for individuals and dependents that voluntarily terminate COBRA continuation coverage, regardless of who is paying the premium. To deny individuals or dependents a SEP once they have selected COBRA, but have not exhausted it, penalizes them for taking up COBRA in an effort to maintain continuity of coverage. If CMS does not establish the broader SEP, HBX supports a SEP related to reduction, regardless of the amount, or cessation of employer contributions for COBRA continuation coverage as a triggering event for SEP eligibility.

### **Special Enrollment Periods (45 C.F.R. §155.420(b)(5) & (c)(5)) – Timely Notice of Triggering Events**

HBX supports CMS' proposed amendment providing flexibility in the determination of a triggering event for SEPs. Specifically, CMS proposes allowing an individual or dependent who did not receive timely notice of an SEP triggering event and was otherwise reasonably unaware that a triggering event occurred to select a new plan within 60 days of the date that they knew, or reasonably should have known, about the triggering event. This change provides consumers that have not received timely notification of a SEP triggering event the same rights and access to health insurance options as those consumers that do receive timely notification. HBX supports this proposal and encourages CMS to finalize as proposed.

### **User Fees 45 C.F.R. §156.50**

The proposed rule would cut the federal marketplace user fee by 25 percent, from 3 percent to 2.25 percent and would cut the user fee for state-based marketplaces that use the federal platform from 2.5 percent to 1.75 percent. HBX opposes this proposal.

The marketplace user fee supports critical federal marketplace functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising.

The Administration asserts that a lower user fee will be sufficient to fund current federal marketplace activities. However, current federal marketplace activities are inadequate as evidenced by rising uninsured rates especially in states using healthcare.gov and on-going losses of coverage in healthcare.gov states<sup>8</sup> and especially high losses of coverage among communities of color. The number of uninsured has increased in 2017, 2018, and 2019, totaling 28.9 million uninsured people in 2019.<sup>9</sup> According to a Kaiser Family Foundation analysis, communities of

---

<sup>8</sup> See State Health Facts, Marketplace Enrollment, 2014-2020, Kaiser Family Foundation, available at <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

<sup>9</sup> "Key Facts about the Uninsured Population," Kaiser Family Foundation, November 6, 2020, available at <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

color made up a disproportional share of the 1.1 million Americans who became uninsured between 2018 and 2019. Of the 1.1 million, 57% were Hispanic people.<sup>10</sup>

The Administration has stopped nearly all marketing and outreach and has slashed funding for Navigators, both of which are core marketplace functions funded by user fees. Under the prior Administration, both functions being well funded helped to contribute to health coverage gains and helped to decrease America's uninsured rate. To get people insured and to mitigate coverage losses, the federal marketplace would need increased budgets for marketing and navigators.

Furthermore, while many state-based marketplaces continue to invest in improving consumer decision support tools and user experience, it is unclear what, if any, improvements have been made to healthcare.gov and whether there are any planned for the future. HHS should provide detailed information on current and projected use of user fees before proposing or finalizing cuts. At a minimum, CMS should make public basic budget information on how much marketplace core functions cost, IT roadmap and cost, and strategy and cost of activities for expanding coverage. These elements are essential to evaluate if any changes to the user fee are warranted.

#### **Annual Premium Adjustment Percentage (45 C.F.R. §156.130(e))**

The proposed rule continues the Administration's change in the formula used to calculate the annual premium adjustment percentage, which was introduced in the 2020 Notice of Benefits and Payment Parameters (NBPP). HBX continues to oppose the new methodology because it has negative effects on marketplace consumers, including reducing the amount of premium tax credits (APTC/PTC) and increasing the maximum out-of-pocket cap (MOOP). As noted in our comments submitted on the 2020 NBPP, CMS has acknowledged that the new methodology could result in a decline in Exchange enrollment and net premium increases for those who remain in the individual market.<sup>11</sup> While CMS admits that "the methodology should have a record of accurately estimating average premiums..."<sup>12</sup>, the agency failed to provide data to justify how the proposed change would more accurately estimate average premiums.

The formula change will have an even greater impact in 2022, raising premiums by an estimated 4.7 percent for most subsidized marketplace consumers after accounting for their tax credits (compared to about 2.7 percent this year). That amounts to a \$360 annual premium increase for a family of four with \$80,000 in income. In addition, under the new formula, the 2022 MOOP will be \$400 higher for an individual, and \$800 higher for families, than if the prior formula were used. The MOOP applies to both individual and group market plans.

HBX strongly opposes the continued use of this new formula because of the negative effect on residents and small businesses. We urge a return to the formula prior to the 2020 NBPP.

---

<sup>10</sup> "Hispanic People are Facing Widening Gaps in Health Coverage," Kaiser Family Foundation, November 6, 2020, available at <https://www.kff.org/policy-watch/hispanic-people-facing-widening-gaps-health-coverage/>.

<sup>11</sup> Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. Notice of Proposed Rulemaking. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 84 Fed. Reg. 227 at 287 (January 24, 2019).

<sup>12</sup> *Id.* at 285.



## **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, disrupt stable markets, and create barriers to consumer enrollment in health insurance. Thank you for considering our comments on issues that will directly impact District residents and employers and the continued operations of our marketplaces. We look forward to working with you on these issues to empower consumers and ensure that consumers have access to quality and affordable coverage.

Sincerely,

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

Mila Kofman  
Executive Director  
DC Health Benefit Exchange Authority

## **APPENDIX A – DC Health Benefit Exchange Authority Comment Letters**

- 1) DC Health Benefit Exchange Authority July 1, 2019 Comment Letter to CMS, Request for Information Regarding State Relief and Empowerment Waivers - CMS-9936- NC2.
- 2) DC Health Benefit Exchange Authority March 2, 2020 Comment Letter to CMS, HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans – CMS-9916-P.
- 3) DC Health Benefit Exchange Authority November 27, 2017 Comment Letter to CMS, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 – CMS-9930.



July 1, 2019

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-9936-NC2  
P.O. 8013  
Baltimore, MD 21244-1850

**Re: Request for Information Regarding State Relief and Empowerment Waivers - CMS-9936-NC2**

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments in response to the administration's Request for Information (RFI) regarding State Relief and Empowerment Waivers.

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. District residents have 25 health plan options from two insurers and small businesses have 152 health plan options from United, Aetna, CareFirst, and Kaiser. Since we opened for business, we've cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

HBX supports efforts to expand affordable quality health coverage, state flexibility under the ACA, and state innovation using section 1332. However, the approach articulated in the RFI is not about state flexibility. It is about turning back the clock to pre-ACA days of underwriting and discrimination. The RFI explicitly reiterates the principles CMS articulated in its 2018 guidance<sup>1</sup> encouraging the growth of junk plans and putting at risk quality health insurance that millions of Americans rely on. We expressed our concerns in 2018 over such policies and continue to have the same concerns now.

The contemplated approach to Section 1332 waivers and 2018 guidance fails to protect people with preexisting conditions, allows states to revert back to the pre-Affordable Care Act (ACA) environment where many consumers, including those with pre-existing conditions, would not have affordable comprehensive coverage and would be forced to seek inadequate coverage in markets that permit medical underwriting, and allows charging sicker people higher rates or denying coverage altogether.

---

<sup>1</sup> Depts. of Health and Human Services and Treasury, Guidance: State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, Oct. 23, 2018.



1225 Eye Street NW, 4th Floor, Washington, DC 20005

Consequently, premiums will increase for District residents with private individual market health insurance. To avoid these negative consequences, we recommend that the Administration reestablish a federal reinsurance program to strengthen the existing individual markets. Seven of the eight approved Section 1332 waivers establish a state-level reinsurance program and six of the seven states with public drafts of a Section 1332 waiver application are to establish a state-level reinsurance program.<sup>2</sup>

### **Adverse Impact on States that Keep ACA Protections**

The CMS approach articulated in 2018 and reiterated in the RFI will have a negative impact on individual private health insurance markets in states like the District of Columbia that keep ACA consumer protections. As articulated in our Comment letter<sup>3</sup>, if other states seek section 1332 waivers to permit the proliferation of junk plans that are not required to include the ACA's consumer protections, individuals who have higher health costs and who need more comprehensive coverage will move to states like the District that retain the ACA's consumer protections. According to Oliver Wyman actuaries, if other states make significant changes to consumer protections of the ACA (e.g., coverage no longer being available to individuals on a guaranteed issue basis, the elimination of community rating, increased availability of plans in separate risk pools from the ACA), the impact of higher cost individuals moving into the District will have a significant negative affect on District residents with individual coverage.

- If merely 100 people who are high cost move to the District from states that weaken ACA protections, claims costs for the individual market will increase by 8.9% and if approximately 800 high cost people move to DC, claims costs will **increase by 24.4%**. (Attachment: Oliver Wyman Analysis)

This concern was true in 2018 and continues to be the case now. CMS's approach to Section 1332 waivers will harm people who live in the District and will harm other states that keep ACA consumer protections.

### **Harm to Consumers in States that Erode ACA Consumer Protections**

CMS's approach to Section 1332 waivers will harm people who live in states that allow the erosion of ACA protections for people with preexisting conditions.

CMS clarified in 2018 and reinforced in the RFI that in evaluating the affordability and comprehensiveness guardrails, they will look at the impacts in the aggregate and not focus on the impacts on vulnerable populations. This would allow states to create waiver programs that disadvantage specific populations, such as lower income or people with chronic illnesses, so long as the

---

<sup>2</sup> H. Howard, State Health and Value Strategies, More States Looking to Section 1332 Waivers, June 3, 2019, <https://www.shvs.org/more-states-looking-to-section-1332-waivers/>. States with a reinsurance program under 1332: Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin. States working on their 1332 applications for a reinsurance program: Colorado, Delaware, Louisiana, New Hampshire, North Dakota, and Rhode Island.

<sup>3</sup> Comment Letter from Mila Kofman, Executive Director, DC Health Benefit Exchange Authority to Secretary Azar and Administrator Verma, Dept. of Health and Human Services on State Relief and Empowerment Waivers – CMS-9936-NC, Dec. 17, 2018 available at [https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/DC\\_HBX\\_Comment\\_CMS\\_9936-NC.pdf](https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/DC_HBX_Comment_CMS_9936-NC.pdf).

aggregate population might experience some benefit (for example, lower premiums for junk insurance). Specifically, the Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper released on November 29, 2018 encourages use of the 1332 waiver to promote short-term limited duration plans (STLD), association health plans (AHPs), and other junk insurance not subject to the same consumer protections as health insurance for individuals and small businesses.

Proliferation of junk plans results in risk segmentation and makes comprehensive coverage less affordable and less available. For example, STLD plans are designed only to cover healthy people by using medical underwriting to reject people with medical needs. Such plans also don't cover preexisting conditions, exclude prescription drugs, maternity care and mental health benefits, and have annual and lifetime limits. When healthy people leave the ACA market and purchase junk plans, premiums increase for people with comprehensive coverage and ultimately makes comprehensive coverage unaffordable. Also, this could result in insurers leaving the ACA market in states that segment markets through the use of section 1332 waivers.

We are concerned that the Administration's approach will cause consumers who need comprehensive coverage and people with preexisting conditions to lose their ACA coverage. We are also concerned that people who want comprehensive private health insurance will no longer have insurance companies from which to buy coverage.

### **Violation of Section 1332 State Innovation Waiver Guardrails**

CMS's waiver guidance misinterprets and contradicts the statutory guardrails for 1332 waivers. Section 1332(b) of the ACA establishes clear statutory guardrails (emphasis added):

**(1) IN GENERAL** - The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—

**(A)** will provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title and offered through Exchanges established under this title as certified by Office [3] of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

**(B)** will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;

**(C)** will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; **and**

**(D)** will not increase the Federal deficit.

The statute requires a state waiver program to provide comprehensive, affordable coverage with cost sharing protections against excessive out-of-pocket spending to a comparable number of residents as would have been covered but for the waiver. The CMS approach articulated in 2018 and reinforced in the RFI conflicts with the statute for the following reasons.

CMS asserted in the 2018 guidance and in the RFI reinforces the idea that a state can meet these guardrails by showing that residents will have *access* to affordable and comprehensive coverage. The guidance does not require any enrollment in affordable and comprehensive coverage. The interpretation contradicts plain meaning of the statute which requires that state waiver programs

actually **cover** a comparable number of people under comprehensive coverage. The author of Section 1332, Senator Ron Wyden, on the Senate floor on December 23, 2009 made this clear by stating (emphasis added):

Exchanges are a new pathway to creating a competitive marketplace for the first time for health care in this country. Massachusetts led the way, opening the door to showing Federal legislators the potential for insurance exchanges when Massachusetts enacted its own health reform law. Many other states lead the way with innovation in health care, including states like Oregon and Vermont. That is why I have authored and championed in the Senate Finance Committee, section 1332, the waiver for State innovation. If States think they can do health reform better than under this bill, and **they cover the same number of people with the same comprehensive coverage**, they can get a waiver exempting them from the legislation and still get the Federal money that would have been provided under the bill.

By interpreting “provide coverage” as merely access to coverage as opposed to actual enrollment, CMS’s interpretation conflicts with the statute.

Furthermore, CMS’s current approach conflicts with the guardrails. CMS encourages the growth of junk plans such as STLD plans and AHPs that do not have the same cost protections against excessive out-of-pocket spending and are not available to people with preexisting conditions or can keep people out through medical underwriting. Allowing this means people with medical needs would not drop their comprehensive coverage but healthy people would. As enrollment in junk plans increases, enrollment in ACA plans will decrease driving up premiums for comprehensive coverage, affecting people who do not qualify for tax credits. Consequently, facilitating the growth of junk plans conflicts with the statutory guardrails.

- STLD and AHPs do not provide comprehensive coverage or are underwritten and therefore do not meet the standards in section 1332(b)(1)(A) and therefore residents enrolled in these plans cannot be counted as toward the requirement that the waiver program cover a comparable number of residents.
- As premiums rise due to increased enrollment in STLD and AHPs, the result will be that comprehensive coverage is less affordable for unsubsidized people, a violation of section 1332(b)(1)(B), which requires affordability to be maintained.
- As healthy people drop comprehensive coverage, it will result in fewer people being covered by comprehensive, affordable coverage with cost sharing protections, a violation of section 1332(b)(1)(C), which requires coverage levels to be maintained.
- Comprehensive, affordable coverage would not even be *available* to a comparable number of people because premiums would be higher.

Furthermore, CMS will allow states to use federal funds to pay for STLD plans, AHPs, and other plans not subject to ACA consumer protections, such as the prohibition on pre-existing condition exclusion periods, guaranteed availability, community rating, and the requirement to provide essential health benefits. There is no provision in the ACA that allows federal tax dollars to be used to subsidize substandard coverage. CMS’s interpretation violates the 1332 guardrails that require waiver programs to ensure that a comparable number of residents are covered under affordable and comprehensive health insurance.

## **Conclusion**

HBX supports efforts to expand affordable quality health coverage, state flexibility under the ACA, and innovation using section 1332. However, we strongly oppose CMS's current approach because it undermines stability of quality affordable health insurance, puts millions of Americans at risk of losing their health insurance, and will increase premiums for people living in states like the District of Columbia that keep ACA protections. CMS's approach fails to protect people with pre-existing conditions and is contrary to the statutory language of the 1332 waiver standards. We request withdrawal of the current approach and the 2018 guidance. Instead, we recommend that CMS establish a federal reinsurance program.

Thank you for considering our comments.

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



March 2, 2020

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-9926-P  
P.O. 8010  
Baltimore, MD 21244-1810

**Re: HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans – CMS-9916-P**

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (DCHBX) appreciates your consideration of our comments.

By way of background, DCHBX 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've opened for business, we have cut the uninsured rate by 50% and now nearly 97% of District residents have health coverage. We offer 156 options to small businesses from Aetna, United Health Care, CareFirst Blue Cross Blue Shield, and Kaiser Permanente. We also offer 25 options to residents from CareFirst Blue Cross Blue Shield and Kaiser Permanente. Two years in a row (2017 and 2018), our consumer decision support tools rank number one among state-based marketplaces and the FFM.

DCHBX supports CMS's proposals that would strengthen markets and the Affordable Care Act (ACA) and strongly opposes proposals that would create barriers to coverage and impose unnecessary administrative burdens. In summary, we oppose the proposal to change auto renewal, oppose the proposed new and burdensome reporting requirements, oppose the proposed new cost sharing requirements, support the proposed changes to incurred claims for MLR specific to prescription drugs, and support certain proposed changes for SEPs. We also greatly appreciate CMS's recognition of state flexibility and encourage continued flexibility for state-based marketplaces.

**Auto "Re-Enrollment" (also called Auto-Renewal)**

CMS is soliciting comments on the existing practice of automatically renewing health insurance coverage when a consumer does not make changes to that coverage. Specifically, CMS appears to be considering either taking away or reducing advance premium tax credits (APTC) for insured people who do not



1225 Eye Street NW, 4th Floor, Washington, DC 20005



“shop” at renewal when the APTC “cover[s] the entire plan premium.”<sup>1</sup> DCHBX strongly opposes this because it will harm insured people, it is prohibited by federal law and contradicts Congressional intent, is contrary to insurance industry practice, and is unsubstantiated by data. This would make premiums unaffordable.

It is not clear whether this is proposed rule-making or a request for information that will be followed by proposed rulemaking. Legally sufficient proposed rulemaking requires “either the terms or substance of the proposed rule or a description of the subjects and issues involved.”<sup>2</sup> The ideas put forward in this proposed rule fall short of the legal requirements in part due to lack of clarity of how and to whom this would apply to. For example, it is not clear what the term “entire plan premium” means. It could mean the entire amount owed for a particular policy. Or it could mean “only” the premium attributable to essential health benefits (EHBs). In many states, including the District, plans include coverage beyond the EHB. APTC can only cover the portion of the premium associated with EHB.<sup>3</sup> Therefore, even customers with a high level of APTC will always have some portion of their premium that they must pay each month.

It is also not clear whether consumers who actively “shop”, but pick the same plan during annual renewal, without submitting updated eligibility information, would be considered to have “auto-renewed” and be subject to APTC removal or reduction.

Despite the ambiguity, it is clear that CMS’s proposal is targeting working Americans who are insured because of the substantial premium reductions provided by APTC. This is not the first time CMS has considered such a policy. CMS first sought input on auto-renewal in its 2020 Notice of Benefit and Payment Parameters NPRM. When that rule was finalized, CMS acknowledged that “commenters who addressed this topic unanimously supported retaining automatic reenrollment processes.” (*Emphasis added*).<sup>4</sup> DCHBX was among those commenters who were strongly opposed to CMS restricting or prohibiting auto-renewal.

Congress also opposed CMS’s efforts to restrict or prohibit auto-renewal. In section 608 of the Further Consolidated Appropriations Act of 2020, an amendment was made to ACA section 1311(c) which required auto-renewal of customers in the FFM who did not actively select a plan and did not actively terminate during the plan year 2021 renewal season.<sup>5</sup> Contrary to the suggestion by CMS in the proposed rule, auto-renewal without APTC does not comply with the Congressional intent of the amendment. Customers receiving APTC, particular those for whom the APTC covers all or nearly all of the premium, will not be meaningfully renewed if their APTC is eliminated or reduced because they won’t be able to pay the full-price premium – the FFM will not be complying with the law.

---

<sup>1</sup> Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Notice of Proposed Rulemaking. “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans,” 85 Federal Register 7088, 7119 (Feb. 6, 2020).

<sup>2</sup> 5 U.S.C. §553(b)(3)

<sup>3</sup> 26 C.F.R. §1.36B-3(j).

<sup>4</sup> Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Final Rule. “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020” 84 Federal Register 17454, 17460 (April 25, 2019).

<sup>5</sup> Further Consolidated Appropriations Act, Pub. L No. 116-94, section 608. (Dec. 20, 2019). (Codified at 42 U.S.C §18031(c)(7)).

Despite the universal opposition to restricting auto-renewal, CMS is once again suggesting alterations to the auto-renewal process and is using unsupported reasoning. CMS cites the following concerns: 1) consumers receiving APTC are less sensitive to premiums and premium changes; and 2) when a consumer's entire premium is paid for with APTC, consumers are less likely to update their information, which leads to eligibility and APTC errors. CMS offers no evidence to support the assertions that auto-renewal leads to any of the alleged problems. The stated concerns are not supported by evidence.

First, CMS fails to provide evidence that consumers with substantial APTC amount are less price sensitive than other consumers. We looked at our experience to test this assumption.<sup>6</sup> We focused on our SHOP experience because APTC is akin to subsidized job-based coverage. Like APTC recipients who do not pay 100% of their premium, workers with subsidized job-based coverage pay only a portion or in some cases nothing when their employer pays part or the entire premium. DC Health Link SHOP data reflects experience of 80,000 covered lives and more than 5,100 small businesses.

Looking at our data for plan year 2018, our experience with the small group market does not support CMS's assumptions related to price sensitivity. If CMS's assumptions were accurate, we would expect to see workers who pay the highest proportion of premium (where employers are contributing the least), shopping at higher rates than workers who pay the least or don't pay at all because their employer pays 100% of premium. For plan year 2018, among workers who were offered more than one plan to choose from, only 5% of workers with an employer contribution of 0% shopped at renewal, while 21% of workers who paid nothing for their premium, because their employer paid 100% of the premium, shopped. Employees with 70-79% and 90-99% employer contributions had the highest rate of plan changes.

EMPLOYER % CONTRIBUTION TO PREMIUM	EMPLOYEES SHOPPING % FOR 2018 PLAN YEAR
0%	5%
36-49%	6%
50-59%	20%
60-69%	21%
70-79%	28%
80-89%	26%
90-99%	28%
100%	21%

\*Employers who offer choice of plans or choice of carriers to workers. This excludes employers who offer only 1 plan.

Also looking at employers that offer only 1 plan, if CMS's assumptions were accurate, we would expect to see employers who pay 100% of the premium to shop at higher rates than employers who contribute less than that. Our data shows that for the 2018 plan year, only 26% of employers paying 100% of the

<sup>6</sup> Since our population of APTC recipients is about 10% of our enrollment and is small compared to our full pay customer population, looking at the behavior of our small group market provides a better understanding of how reduction in premium (because the employer pays a portion) impacts customer shopping at renewal.

premium shoppers compared to 28% of employers paying 50-99% of premium. In other words, employers who contributed less actually shopped more.

EMPLOYER* CONTRIBUTION TO PREMIUM	2018 % of <u>employers</u> actively shopping
50-99%	28%
100%	26%

Based on our experience there is no basis for CMS’s suggestion that customers receiving APTC are less price sensitive. Also, Federal Employees Health Benefit Plan (FEHBP) reports that approximately 6% of covered federal employees make a plan change during open season.<sup>7</sup> On average around 13% of Medicare Part D enrollees make active plans selections.<sup>8</sup>

CMS’s justification also includes concern over wasteful use of limited federal dollars subsidizing coverage that people may not want. This justification also falls apart under scrutiny. The tax advantages provided to employer sponsored coverage (ESC) dwarf those associated with premium tax credits. Tax subsidies for ESC cost the federal government approximately \$260 billion in 2017<sup>9</sup> whereas premium tax credits for the same year were less than \$28.8 billion.<sup>10</sup> If the subsidy for ESC were treated as a budget item, it would be the government’s third largest expenditure on health coverage, after Medicare and Medicaid, which were \$591 billion and \$375 billion respectively in 2017.<sup>11</sup> CMS’s decision to target the APTC population for savings when federal expenditures to support their coverage is comparatively small, and their market behavior is so similar to other populations, is unjustified.

If the real goal is to encourage active shopping, then CMS needs to have the right decision support tools that work for different age groups, different populations, different health insurance literacy levels, and are culturally and linguistically appropriate for different populations. And, for people who don’t use the on-line system but instead use navigators, CMS should increase funding through grants to navigators to ensure that all of those people have the in-person support they need. For consumers who use brokers, CMS should consider commission support for re-enrollment every year. In the context of privatizing many functions of Healthcare.gov, it is unclear whether CMS plans to share consumers’ private confidential information with web-based enrollers and others to ensure consumers with APTC can re-enroll each year. It is clear that there is no funding for a robust paid media campaign to educate people that CMS will take away or reduce their APTC even though in prior years, the APTC was renewed.

<sup>7</sup> Jory Heckman, “Open Season Ends Today: Here’s What You Need to Know,” Federal News Network, December 8, 2017, available at: <https://federalnewsnetwork.com/open-season/2017/12/open-season-ends-dec-11-heres-what-you-need-to-know/>.

<sup>8</sup> J. Hoadley, E. Hardgrave, L. Summer, et. al., “To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money?,” Kaiser Family Foundation, October 10, 2013, available at <https://www.kff.org/report-section/to-switch-or-not-to-switch-issue-brief/>.

<sup>9</sup> Aaron E. Carroll, The Real Reason the U.S. Has Employer-Sponsored Health Insurance, N.Y. Times, Sept. 5, 2017. Available at: <https://www.nytimes.com/2017/09/05/upshot/the-real-reason-the-us-has-employer-sponsored-health-insurance.html>

<sup>10</sup> Internal Revenue Service. SOI Tax Stats - Individual Income Tax Returns Publication 1304. 2017- Table 2.7: All Returns: Affordable Care Act Items. Available at: <https://www.irs.gov/pub/irs-soi/17in27aca.xls>

<sup>11</sup> Congressional Budget Office. “The Federal Budget in 2017: An Infographic” March 5, 2018. available at: <https://www.cbo.gov/publication/53624>

The second concern CMS articulates is about APTC eligibility errors. Eligibility errors should be addressed based on data of what the errors are and not by arbitrarily discontinuing the tax credits for those that are most in need. CMS provides no data that there is enhanced risk associated with this population of APTC recipients. The existing processes already address any risk. For example, there are existing processes that require marketplaces to recheck the federal hub at renewal and to create outstanding verifications if there are discrepancies.<sup>12</sup> Each year, DCHBX sends all customers receiving APTC a notice informing them of the information that will be used to determine their enrollment and Insurance Affordability Program eligibility for the upcoming year; this includes any updated information received based on checks with the federal hub. These notices are sent in September so that the customer has 30 days to respond with any updates. In preparation for the federal hub check, DCHBX reviews our records for potential APTC-eligible customers where the consent to check IRS records has expired. If the IRS consent is not active, the customer cannot receive an APTC renewal.<sup>13</sup> Therefore, we call these customers to have them renew their consent to ensure we can have the most accurate information. A second notice is then sent in October to all APTC customers, prior to the beginning of Open Enrollment with the eligibility determination. Included in these eligibility notices will be customers who will not receive APTC because the exchange received notification from IRS that the customer failed to file or failed to reconcile APTC received on a prior tax return.<sup>14</sup> DCHBX conducts enhanced outreach to these customers to request updated copies of their tax returns or to connect them with tax professionals who can help them file amended returns. All of these are direct ways that we inform customers about their APTC. This oversight also ensures that residents get appropriate APTC. Additionally, to mitigate the risk of customers having to pay back APTC, our shopping experience makes it very easy for customers to select less than the entire amount they are eligible for. Our shopping experience includes a default of 85% of the APTC amount a customer is found eligible for. Customers can either take less or more and 32% select less than the amount of APTC for which they qualify.

To enhance existing approaches, the FFM should consider additional education and outreach to help consumers better understand the requirement to report changes within 30 days that may impact eligibility. Navigators can also help consumers to better understand these requirements. CMS should increase funding for navigators to help educate consumers. Instead of taking positive steps to help consumers with APTC become smarter shoppers, CMS has created a thinly veiled scheme targeting workers most in need of financial assistance, the lowest income people and families, creating new eligibility requirements designed to kick people out of quality private health insurance by taking away their reduced premiums.

*Harmful to Consumers and Insurance Markets* – Any alteration, restriction, or prohibition related to auto-renewal will create consumer confusion, add barriers to coverage, and could result in millions of Americans losing their current health insurance coverage leaving them uninsured. It would also increase premiums for insured consumers.

Consumers have been auto-renewed in marketplace coverage since the inception of marketplaces, and insurance consumers of all types have always been auto-renewed into coverage when eligible as discussed below under industry practices. Even if the federal government increased its outreach and

---

<sup>12</sup> See 45 C.F.R. §155.335

<sup>13</sup> Id. at (k) & (l).

<sup>14</sup> See 45 C.F.R. §155.305(f)(4).

education efforts, there will be many consumers who either won't know about the change, won't understand the change, and/or won't act. Furthermore, people who are sick and need coverage are more likely to act than people who are healthy. This will result in premium increases as healthy people fail to act and are dropped from coverage. CMS should expect millions of Americans to lose their health insurance if it moves forward with any changes to auto-renewal. CMS repeatedly decries the harms of rising premiums, yet here proposes an administrative change that would directly cause such increases.

*Industry Practice* - In the entire insurance industry, not just in the health insurance industry, the norm is for carriers to automatically renew insurance policies. This is true for life and health insurance, property and casualty insurance, liability and other lines. In fact, CMS acknowledges that "automatic re-enrollment significantly reduces issuer administrative expenses, makes enrolling in health insurance more convenient for the consumer, and is consistent with general health insurance industry practice"<sup>15</sup> but nonetheless is still seeking to restrict auto-renewal.

Furthermore, the practice in job-based coverage is that workers keep their health plan without any action on their part. It is not common and actually unheard of for an employer to force employees to actively reenroll in their health plan even where the employer pays 100% of the employees' premium. Also, even governmental plans auto-renew workers. The health plan for federal government workers, FEHBP, automatically renews and does not require government employees to take action in order to keep their health benefits. Even looking at Medicare, the federal government does not require Medicare beneficiaries to make an active selection every year. Instead, beneficiaries have an opportunity to switch, and those who do nothing, get to keep their Medicare coverage. The norms in the insurance industry, the employee benefit industry, and Medicare is that health insurance is automatically renewed unless a person actively makes a change.

*Contrary to Federal Law and Congressional Intent* – Congress made clear, both when it passed the Affordable Care Act (ACA) and recently with the passage of an amendment to section 1311(c) of the ACA, that consumers are to receive prompt and continuous eligibility and enrollment. The proposed approach put forward by CMS is contrary to law.

The ACA sets forth eligibility standards for APTC. There is no discretion given to CMS to add additional requirements, such as requiring some APTC qualified people to shop at renewal. And if they don't shop, then they would not qualify for APTC. This criteria is not in the statute. Adding such criteria is akin to rewriting the statute, which is beyond the authority of federal agencies. Furthermore, exchanges are required to make APTC eligibility determinations. CMS does not cite statutory authority that would allow an exchange to deny or modify the APTC amount based on the fact that the eligible consumer failed to shop at renewal. Importantly, the 2019 amendment to ACA section 1311(c) explicitly requires auto-renewal. CMS's approach is contrary to the clear intent expressed by Congress through statutory amendment to section 1311(c). Customers receiving APTC, particularly those for whom the APTC covers all or nearly all of the premium will not be meaningfully renewed if they don't receive APTC because they won't be able to pay the full-price premium. Therefore, CMS's approach does not comply with 1311(c) and is contrary to federal law.

*CMS Actions Have Harmed the Individual Market* - Any proposal to eliminate or restrict auto-renewal must be viewed in context with other actions that have caused premiums to rise, have led to people

---

<sup>15</sup> HHS Notice of Benefit and Payment Parameters for 2021, at 7119.

losing their coverage, and have had a destabilizing impact on private health insurance markets and undermined the ACA. In addition to public statements by Administration officials, here are some examples from the Administration's record:

- Stopped reimbursing Cost-sharing reductions (CSRs) (causing premiums to increase and affecting decisions by some carriers to leave markets);
- Slashed paid media and education budget (negative impact reflected in lower enrollment);
- Slashed Navigator grant budget (negative impact reflected in lower enrollment);
- Enabled proliferation of junk plans like short-term, limited-duration plans and association health plans (will destabilize markets and open door to fraud and abuse)
- Created new barriers for people experiencing qualifying life events (will make people uninsured);
- Created new barriers for women seeking access to basic health care services (millions of women may lose coverage as a result);
- Expanded "public charge" rule to include health coverage like Medicaid (causing a chilling effect on immigrants who plan to apply for a green card, with many foregoing health insurance coverage due to fear of being denied citizenship in the future).

CMS' current approach will mean that APTC recipients, who are sick, will do what they need to keep their APTC, while the healthy population will drop out of coverage. This will increase premiums for full pay and APTC customers who remain covered.

Key to market stability is flexibility for states to adopt appropriate interventions and consumer protections to ensure stable markets that work for consumers. States have different markets and federal regulations need to recognize that. DCHBX supports market-stabilizing solutions, flexibility for states to build on federal standards, and policies that help people obtain affordable, quality health insurance. We oppose policies that may disrupt stable markets, and create barriers to consumer enrollment and renewal of health insurance. We strongly oppose requiring State-based marketplaces (SBMs) to restrict auto-renewal even if CMS requires it of the FFM.

**State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020, and Annual Reporting of State-Required Benefits (45 C.F.R. §156.111)**

CMS is proposing to amend 45 C.F.R. §156.111 to add a new section (f) that would require states to file an annual report to the U.S. Department of Health & Human Services (HHS) on state mandated benefits starting plan year 2021. As proposed, states would be required to annually: report all state benefit mandates; the date of enactment, including whether they were passed before or after December 31, 2011; identify which benefit mandates are in addition to essential health benefits and are subject to defrayal under 45 C.F.R. §155.170; identify which benefits are not in addition to essential health benefits and the basis for the state's determination; and other information about mandated benefits as required by HHS. A state official would be required to sign the report and provide an annual update. As proposed, if a state fails to submit this report, HHS would complete a similar report for the state and make its own determinations about whether or not a state mandate is subject to the defrayal process required under §155.170. CMS is also seeking comments on an alternative option: whether CMS should conduct the annual review of state laws instead of states reviewing their own laws.

DCHBX strongly opposes both and requests that CMS withdraw the proposal and reject the alternative. Similar to other ACA implementation and compliance issues, CMS should address compliance concerns directly with the state(s) at issue.

CMS explains that the new state reporting requirement would ensure compliance with the federal requirement for states to defray costs of new benefit requirements. However, CMS fails to provide any evidence that there is an issue with compliance with this requirement. CMS only states that unnamed stakeholders have concerns that there “may be states” not defraying costs. CMS should address any concerns with compliance with an individual state or states, not create new administrative burdens and an unnecessary process applicable to all states. The proposal is a new administrative burden, the type the Administration instructed agencies to reduce to the maximum extent permitted by law. Specifically, President Trump issued an Executive Order that stated “to the maximum extent permitted by law, to afford the States more flexibility and control to create a more free and open health care market; provide relief from any provision or requirement of the PPACA that would impose a fiscal burden on any State....”<sup>16</sup> Further, in 2017, CMS solicited comments on “...changes that could be made, consistent with current law, to existing regulations under HHS’s jurisdiction that would result in a more streamlined, flexible, and less burdensome regulatory structure, including identifying regulations that eliminate jobs or inhibit job creation; are outdated, unnecessary, or ineffective; impose costs that exceed benefits; or create a serious inconsistency or otherwise interfere with regulatory reform initiatives and policies.”<sup>17</sup>

This proposal not only contradicts President Trump’s Executive Order and CMS’ purported goals of reducing regulatory burden, but it would also create and impose new regulatory burdens on states. The new reporting structure would require state officials to either procure consultants or divert existing staff from other work to comply with an entirely new reporting process.

CMS’s two options -- doing an analysis for all states or just for states not able to do the analysis themselves -- do not take into account the numerous state insurance regulation activities related to whether something is a benefit mandate. If CMS incorrectly interprets a state requirement, that interpretation would interfere with state form review, rate review, plan certification, market conduct exams, enforcement, and even consumer assistance. State insurance regulation and oversight dates back to the 1800s, has been recognized by Congress in McCarran Ferguson – states being the primary

---

<sup>16</sup> Centers for Medicare and Medicaid Services, “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choice To Empower Patients,” 82 Fed. Reg. 26885, 26886 (June 12, 2017).

“On January 20, 2017, President Trump issued Executive Order 13765, ‘Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal,’ to minimize the unwarranted economic and regulatory burdens of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148). To meet these objectives, the President directed the Secretary of Health and Human Services (the Secretary) and the heads of all other executive departments and agencies with authorities and responsibilities under the PPACA, to the maximum extent permitted by law, to afford the States more flexibility and control to create a more free and open health care market; provide relief from any provision or requirement of the PPACA that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications; provide greater flexibility to States and cooperate with them in implementing health care programs.....” Id.

<sup>17</sup> Id. at 26886.

regulators of insurance, and by the Supreme Court. If a state retains its state insurance oversight responsibilities and there is a conflict with CMS' interpretation, it is not clear what options exist except for CMS to overrule state Legislatures' and Executives' will, state insurance Commissioners' authority, and marketplace exchanges' state-based authority. Consequently, although we appreciate the two alternative to alleviate the new burden on states, neither one is a practical alternative that recognizes the role of states in regulating insurance, keeping markets stable, and protecting insurance consumers.

Additionally, different from the authority CMS has to implement federal law in states that refuse or unable to, in this case CMS is giving itself authority to interpret state insurance law. Neither the ACA nor other laws related to health insurance give CMS authority to interpret state insurance law.

DCHBX requests that the proposal and the alternative option be withdrawn.

### **Cost-Sharing Requirements (45 C.F.R. §156.130(h))**

CMS is proposing a change to coverage of prescription drugs under essential health benefits (EHB) that would permit qualified health plans to exclude prescription drug coupons from the annual out-of-pocket limit due to a regulatory conflict between the CMS regulations and Internal Revenue Service (IRS) guidance governing high deductible health plans. This proposal would exacerbate the negative effects of the modification that CMS finalized in the 2020 Notice of Benefits and Payment Parameters.

In the 2020 Notice of Benefits and Payment Parameters, CMS amended 45 C.F.R. §156.130 to allow carriers to exclude any form of direct support from drug companies, including coupons, from a consumer's annual out-of-pocket limit on cost-sharing only if a generic equivalent prescription is available. DCHBX opposed this change when it was proposed and we oppose the new proposal that would expand this provision to allow carriers to exclude any form of direct support, such as coupons, from a consumer's out-of-pocket limit regardless of the availability of a generic equivalent.

When originally proposed, CMS stated the intent was to encourage the use of generic equivalent medications and to address the rising costs of prescription medications by promoting the use of more affordable generic alternatives when they were available. The new proposal eviscerates this argument and allows carriers to shift prescription drug costs onto consumers in all cases. Coupons from drug manufacturers are made available to off-set the cost of new or expensive prescription medications which may be the only medically appropriate treatment. This proposal would unduly harm consumers who need financial assistance to afford needed care, and this proposal could result in discriminatory practices that directly target people with rare or expensive conditions.

As DCHBX previously commented, this provision places the burden of fixing a systemic problem related to cost and coverage of prescription medications on the backs of consumers. Under this proposal, consumers may incur unexpected costs due to no fault of their own. Some people will choose not to fill necessary prescriptions due to cost. Instead of shifting costs to consumers, CMS should work with other federal agencies and stakeholders to address the costs of prescription drugs and better educate consumers on the availability and safety of generic equivalent medications where they exist.

DCHBX encourages CMS to continue to consider options to address increasing health care costs that do not penalize consumers and discourage people from getting medically appropriate care. Any new policies should protect people from discriminatory practices that target people based on their medical needs.



DCHBX strongly opposes this proposed expansion of an already problematic policy of shifting costs to patients. While DCHBX acknowledges the conflict in law CMS regulations created related to high deductible health plans, the CMS created conflict should not be used now as a subterfuge to shift more costs to patients who need prescription medication.

### **Medical Loss Ratio**

#### ***Other Non-Claims Costs (45 C.F.R. §158.160)***

CMS is proposing to require that carriers deduct price concessions received by the carrier or an entity providing pharmacy benefit management services to a carrier, including prescription drug rebates, from incurred claims. CMS estimates that this will result in \$18.4 million in savings to consumers. DCHBX supports this proposal because it would result in cost savings for consumers and ensure that claims costs only include revenues extended on enrollee pharmacy costs

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

CMS is proposing several changes to the special enrollment period (SEP) provisions under 45 C.F.R. §155.420. First, CMS is proposing to create a new a SEP under §155.420(d)(1)(ii). The new SEP would allow consumers to enroll into individual market coverage when they become newly eligible for a qualified small employer health reimbursement arrangement (QSEHRA) or change individual market plan elections to take advantage of the benefits offered by electing a QSEHRA. DCHBX supports this proposal because it would provide workers the opportunity to take advantage of newly available funding from their employers toward health insurance coverage and encourages CMS to finalize this SEP as proposed.

Second, CMS is proposing to amend §155.420(b)(3) to provide more flexibility to allow earlier effective dates for special enrollment periods. This proposal would allow exchanges to make coverage effective sooner for consumers, reducing possible gaps in coverage that may result from the current effective date rules. This proposal would also allow exchanges to determine appropriate effective dates for their customers and make consumer-friendly effective date policies more consistent. DCHBX supports this proposal and encourages CMS to finalize as proposed.

Third, CMS is proposing to amend §155.420(a)(4)(ii)(B) to permit enrollees and their dependents who experience a qualifying event under §155.420(d)(6)(i) or (ii) resulting in a loss of cost sharing reductions (CSRs), to change their enrollment from a silver plan to a gold or bronze level plan. When a consumer experiences a loss of CSRs they should be permitted to change plans to ensure their plan is affordable and otherwise meets their needs based on their change in circumstances. DCHBX supports this proposal and encourages CMS to finalize as proposed.

Finally, CMS is proposing to amend §155.420(a)(4)(iii)(C) to further restrict the ability of consumers to change metal levels when they experience a qualifying event. DCHBX continues to oppose restrictions on changing metal levels, which we believe to be arbitrary and capricious and contrary to longstanding HIPAA SEP rights, which required that eligible individuals have the same election rights as regular enrollees, including the right to select from any plan available. DCHBX asks that CMS eliminate metal level restrictions for all eligible individuals. CMS has recognized that a “one-size fits all” approach is not workable in all states. If CMS retains these restrictions that limit consumer choice, DCHBX asks that these restrictions only apply to the FFM and not to SBMs.

### **Requirements for Timely Submission of Enrollment Reconciliation Data (45 C.F.R. §156.265)**

CMS is proposing to amend 45 C.F.R. §156.265(f) and (g) to clarify the QHP reconciliation process with exchanges. The proposed clarifications will help improve the reconciliation process allowing both QHPs and exchanges to have timely and accurate data. DCHBX supports these proposals.

### **Eligibility Redetermination During a Benefit Year (45 C.F.R. §155.330)**

DCHBX supports the proposed flexibility provided to exchanges to not terminate QHP coverage without an explicit request from the customer in certain cases where the customer has more than one type of minimum essential coverage. Additionally, DCHBX supports CMS' clarifications regarding expeditious retroactive termination of customers for whom there is evidence of death via a periodic data match. These positive changes will enhance consumer experience with private health insurance.

### **Annual Premium Adjustment Percentage**

CMS adopted a new methodology to calculate the annual premium adjustment percentage in the 2020 Notice of Benefits and Payment Parameters. This methodology is maintained in this proposed rule for PY2021. We continue to oppose the new methodology because it has negative effects on marketplace consumers, including reducing the amount of premium tax credits (APTC/PTC) and increasing the maximum out-of-pocket cap (MOOP) for plan year 2021. The new approach means that MOOP would increase by 4.9% from 2020 to 2021. Under this methodology an individual MOOP would increase to \$8,550. As noted in our comments submitted on the 2020 proposed Payment Notice, CMS has acknowledged that the new methodology could result in a decline in Exchange enrollment and net premium increases for those who remain in the individual market.<sup>18</sup> While CMS admits that “the methodology should have a record of accurately estimating average premiums...”<sup>19</sup> the agency failed to provide data to justify how this change would more accurately estimate average premiums.

We strongly oppose the continued use of this new methodology because of the negative effect on consumers who receive APTC and an increase in financial exposure for all people who now have individual health insurance.

### **State Flexibility**

Key to market stability is flexibility for states to adopt appropriate interventions to ensure stable markets that work for their 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 stakeholder support. States built on-line marketplaces to reflect state and local priorities.

We appreciate that the role of states is recognized and promoted. Executive Order 13765, issued January 20, 2017, instructs agencies to “provide greater flexibility to States and cooperate with them in implementing healthcare programs.” Consistent with this principle, we encourage CMS to continue to

---

<sup>18</sup>Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. Notice of Proposed Rulemaking. “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 84 Fed. Reg. 227 at 287 (January 24, 2019).

<sup>19</sup> Id. at 285.

support state flexibility in all areas covered by the NPRM including but not limited to auto-renewal, employer-sponsored plan verifications, eligibility appeals, and quality rating systems and enrollee satisfaction survey systems. States understand local health insurance markets and the needs of the communities we serve. We support a strong federal floor of basic consumer protections with state flexibility to go beyond the basic federal floor.

### **Conclusion**

DCHBX supports market-stabilizing solutions, flexibly 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 issues that will directly impact DC residents and the continued operations of our marketplace. We look forward to working with you on these issues to empower consumers and ensure that consumers have access to quality and affordable coverage.

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



November 27, 2017

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-9930-P  
P.O. 8016  
Baltimore, MD 21244-8016

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 – CMS-9930**

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments on the above-cited Notice of Proposed Rulemaking (NPRM).

By way of background, HBX 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](http://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. Leveraging the Affordable Care Act (ACA) 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.

We are proud of our success and appreciative of CMS for implementing the ACA in regulations that give state-based marketplaces (SBMs) flexibility to serve local needs. Some proposals in the NPRM continue this flexibility for SBMs, and these we support. A few proposals have the opposite effect and unintended consequences of impeding SBMs, and these we oppose. We urge CMS to continue supporting state flexibility.

**State Flexibility**

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 stakeholder support. States built on-line marketplaces to reflect state and local priorities.

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

We strongly believe that states are in a much better place than CMS to understand local health insurance markets. We support a strong federal floor of basic consumer protections with state



1225 Eye Street NW, 4th Floor, Washington, DC 20005

flexibility to go beyond and have even stronger consumer protections.

We strongly support the state flexibility proposed in this rule with respect to 155.320(d) – the proposal to continue letting states use an alternative process to verify eligibility for employer sponsored health insurance. Additionally, although we appreciate the stated goal of greater state flexibility in the area of EHB (section 156.111), we are concerned that as proposed consumers will lose protections and the minimum standards for coverage under the ACA. The proposal to allow substitutions between benefit categories under section 156.115 undermines the benefit requirements under section 1302 of the ACA and could result in some consumers losing benefits that are currently covered by their health insurance.

We also support the comments submitted by SBMs encouraging CMS to provide additional state flexibility on the annual open enrollment period in marketplaces.

### **Effective Dates Under Guaranteed Available of Coverage 147.104**

HBX strongly opposes the proposal to apply the effective dates currently in use in FF-SHOP to the entire small group market, including SHOP marketplaces, under 147.104(b). This proposal would eliminate flexibility states have currently for effective dates for coverage for their SHOPS. CMS did not provide evidence or public policy reasons to justify eliminating state flexibility. In this case, a “one-size fits all” approach will be disruptive and will create extensive IT and operational costs on SHOP marketplaces. HBX urges CMS to maintain its stated commitment to state flexibility by withdrawing the proposed change to 147.104(b) and instead retain current SHOP flexibility to establish effective dates that work for their markets.

### **Navigator and Assister Program Standards**

HBX opposes the proposal to remove the requirement that Navigators and assisters have a physical presence in the service area they serve under 155.210 and 155.215. HBX has found that entities providing enrollment assistance, including Navigators, assisters, and the broker community, are best able to serve the local community when they have a direct link to the community. In the District of Columbia, we have implemented an approach to consumer assistance that leverages experts from different types of organizations that have strong ties to the community. Our comprehensive approach provides consumers with the best available expertise. For example, HBX Navigators have developed strong relationships with brokers, enabling the Navigators to refer consumers to brokers for help choosing health insurance coverage. The local broker community in the District provides exceptional service to DC Health Link customers and works closely with HBX staff on issue resolution. DC Health Link’s success in part is due to the quality of service provided by HBX staff, HBX assisters and navigators, business partners and the local broker community. This type of consumer assistance is only possible because HBX works with Navigators, assisters, and brokers that have strong ties to the local community. HBX encourages CMS to retain this requirement, so that consumers across the country will continue to have access to the best possible consumer assistance services.

### **Direct Enrollment**

HBX continues to oppose direct enrollment by issuers and web-brokers. With the purchasing power of thousands in DC’s State-Based Marketplace, HBX advocates for our customers to get the best possible premiums and to empower our customers to make informed decisions. 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 the insurance company they enrolled with. DC Health Link small business customers have access to 151 different QHPs from four large insurers and individual marketplace customers have access to 26 different QHPs. We have employer and employee choice – enabling small businesses to select a metal level and allow employees 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 (financial liability and benefit design standardized) 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 DC Health Link Plan Match powered by Consumer 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.

To allow QHP issuers and web-based brokers to build eligibility connections to the federal HUB services 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 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.

Any direct enrollment that is allowed needs to be closely monitored by CMS and should be subject to all of the same requirements that apply to marketplaces. Entities that conduct enrollment into QHPs are providing a service that requires consumers to put a great deal of trust in them, as consumers are required to disclose sensitive information to obtain an eligibility determination. Consumers are able to put their trust in marketplaces because marketplaces are subject to rigorous standards to ensure that consumers are not put at risk. Failure to hold direct enrollment entities to the same rigorous standards exposes consumers to unnecessary risk.

Consistent with our prior comments, if CMS intends to continue to permit direct enrollment, HBX continues to recommend that CMS have a clear and transparent oversight plan. HBX has concerns with any proposal that would weaken CMS’s role in conducting oversight of the entities conducting direct enrollment, including the proposal under 155.221 that entities conducting direct enrollment would be responsible for finding and selecting an entity to conduct annual operational readiness review, without any guidance or oversight by CMS that ensures that direct enrollment entities are contracting with competent and impartial third party entities. Unlike SBMs, private web-based enrollers are not subject to state audits and oversight. Consequently, more, not less, oversight is necessary by CMS to protect consumers.

## **Income Verification**

CMS proposes to add additional verification standards for some applicants for whom income attestations would have been sufficient, when the attestation was to a higher income than the data sources showed. The new requirement will force SBMs to change their IT rules engines and will increase the number of customers who fail the reasonable compatibility tests and need manual verification. HBX takes manual verification very seriously, and thus it is a demanding and burdensome process. It should be reserved for only the most complex cases – not cases where customers think they have higher incomes than the data sources show.

## **Exchange Eligibility Standards**

CMS proposes to remove the requirement to provide notice to consumers who receive APTC but have failed to reconcile under 155.320(c). We are concerned that this approach would deprive consumers of their due process rights. We encourage CMS to reexamine.

## **Annual Eligibility Redetermination**

CMS asked for comments on a proposal to reduce the time period that customers can authorize SBMs to retrieve updated tax return information as described in 155.335(k)(2). The current maximum is five years. Our experience shows that far from wanting a shorter period, customers would prefer longer or indefinite period because a longer period helps them retain coverage. As a matter of practice HBX contacts customers whose authorization is expiring. Based on our experience, residents renew the authorization rather than lose their APTC and many residents believe the authorization was not time limited. HBX recommends that CMS adopt a proposal that would enable customers to authorize an indefinite period until the customer terminates the authorization or terminates coverage with APTC/CSR.

## **Special Enrollment Periods**

CMS proposes several changes to the SEP provisions under 155.420. HBX supports the proposed change to 155.420(a)(5) to create an exception to the prior coverage requirement for consumers who are permanently moving from a location in the United States where QHPs are not available.

However, HBX opposes the proposal to change the effective dates that marketplaces can offer consumers who qualify for a SEP based on birth, adoption, fostering, or court order. This proposal would reduce state flexibility and reduce consumer access to coverage by removing an option for retroactive coverage. Further, this proposal would burden marketplaces with costly, unbudgeted changes to IT systems.

## **Terminations**

HBX supports the proposal under 155.430(d) to remove the 14-day advance notice requirement for terminations. This change would reduce burdens on consumers seeking to terminate their individual marketplace coverage. HBX worked with health insurance carriers to eliminate the advance notice requirement in our individual marketplace, and we applaud CMS for proposing this helpful change.

## **SHOP**

In DC, the small business SHOP continues to grow and thrive. Today it serves over 75,000 people. Some employers are offering coverage for the first time. In a 2016 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. There are 3 United companies, 2 Aetna companies, CareFirst and Kaiser all competing for small businesses and offering 151 different products with price points that are the same as prior years or in a few cases lower rates than prior year's rates through DC Health Link SHOP. 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.

- **Competition:** For the first time, insurers are competing based on price and quality for small business customers.
- **Purchasing Power:** For the first time, small businesses have the purchasing power that once only large employers had.

CMS has proposed sweeping changes to the SHOP regulations under 155.700 *et seq.* The proposals would remove requirements for SHOP marketplaces to perform several key functions, including conducting employee eligibility determinations, facilitating employer and employee enrollments into QHPs, and providing premium aggregation. In some instances, CMS proposes to eliminate these functions, and in other instances CMS proposes to authorize other entities, such as insurers or employers to be responsible such certain requirements.

These proposals would effectively dismantle ACA SHOPs. For example:

Online enrollment as the key method of facilitating enrollment into QHPs is a cornerstone of the SHOP design under the ACA. 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 eliminate these key benefits.

Premium aggregation is another core SHOP function that allows employers to offer true employee choice. Current SHOP functionality enables this choice by freeing employers from the burden of managing premium billing processes from multiple health insurance carriers. Approximately 61% of people in DC Health Link SHOP chose their coverage among many QHPs offered by their employers. Without premium aggregation, it is difficult or impossible for small businesses to offer a choice of multiple insurers and plans to their employees.

If CMS intends to proceed with the proposals to eliminate SHOP enrollment functionality and premium aggregation in FF-SHOP, HBX recommends that CMS provide data on the number of employers currently offering employee choice in FF-SHOP and provide annual updates on that data, so that CMS, stakeholders, and policymakers can monitor the impact of this change on employee choice in SHOP.

While federal efforts with SHOP have been challenging, some states have been successful in setting up SHOP marketplaces. We interpret the proposed rules to preserve SHOP marketplaces without creating new administrative or technical burden for SHOP marketplaces. Accordingly, we assume that SBM SHOP marketplaces can continue operating under existing policies, including policies governing employer and employee eligibility determinations and enrollment into QHP coverage, without interruption and without new CMS review. In particular, HBX assumes that CMS will not prohibit SBMs from continuing to do what they have been doing under the ACA including to collect the data necessary to conduct employee enrollments, conduct eligibility verifications, and establish and enforce enrollment processes, including rules governing the effective dates of coverage in SHOP. The DC SHOP marketplace opened for business on October 1, 2013 and has undergone extensive CMS review and oversight. HBX will assume that SBM SHOP marketplaces choosing not to implement the reduced standards proposed by CMS can continue operating without interruption.

However, because the proposed regulations create confusion for SBM SHOP marketplaces that intend to maintain full services to our consumers, HBX asks CMS to clarify specifically that the current federal regulations governing eligibility determinations, employer and employee enrollments, and premium aggregation would continue to remain in force where SHOP marketplaces continue providing those services to their consumers. It is essential that SHOP



marketplaces continue to have authority to act in these areas, and that any standards established by carriers under proposed 156.286 would need to be consistent with SHOP policies. In other words, we assume that it is not the intent of CMS to preempt current SBM SHOP practices. Failure to provide this clarification would create confusion in the SHOP marketplaces and would create administrative and operational burdens for states. HBX specifically recommends that CMS leave existing regulations in place, rather than having them sunset. HBX also recommends clarifying that proposed new provisions governing employee enrollment, premium aggregation, and other functions that FF-SHOP will no longer perform would only apply to the extent that an SBM marketplace chooses not to perform such functions.

### **User Fee for SBE-FP**

HBX supports the concerns raised by others states regarding the user fee for SBE-FP. SBE-FP states should be assessed a significantly lower fee than that charged by CMS to issuers in FFE states, as SBE-FPs provide substantial value and reduce CMS costs and workloads in core program areas.

Bringing the SBE-FP fee in line with fair market value, providing SBE-FP states with regular and routine access to data, and providing access to consumer assistance tools may attract more interest from states to pursue the SBE-FP model.

HBX encourages CMS to fully consider and address the comments provided by SBE-FP states regarding the fee charged to those states.

### **Conclusion**

DCHBX supports market-stabilizing solutions, flexibly 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 issues that will directly impact DC residents and the continued operations of our marketplaces. We look forward to working with you on these issues to empower consumers and ensure that consumers have access to quality and affordable coverage.

Sincerely,



Mila Kofman  
Executive Director  
DC Health Benefit Exchange Authority