



July 28, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS-9906-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: HHS Notice of Benefit and Payment Parameters for 2022 (Part 3) – CMS-9906-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments in support of the proposed rule.

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.

Lengthening Open Enrollment

HBX supports the proposal to amend 45 C.F.R. 155.410(e) to extend open enrollment through January 15th of each plan year. Our support of the proposal is based on our experience. The end of the year is a particularly busy time for individual market consumers, and some do not realize they need to enroll or make a plan change until after the plan year has started. Additionally, a person may be late paying or misses a payment at the end of a year. Such an individual may only learn of the termination of coverage in January when he or she attempts to use it. To continue open enrollment into January would provide these consumers with a short window to learn of their loss of coverage and still have the opportunity to enroll in coverage for the year. This window is especially critical given the District's tax penalties for lacking minimum essential coverage.

Special Enrollment Period for APTC-eligible Low-Income Individuals

HBX supports the proposal to create a special enrollment period (SEP) opportunity for APTC-eligible individuals and their dependents to enroll in or change plans in any month if their



income is at or below 150 percent of the federal poverty level. The new SEP would be easily implemented by HBX through our existing rules engine. Finalizing the proposal quickly would assist HBX in making the new SEP available for the 2022 plan year.

This proposal will encourage enrollment by the most vulnerable populations and, as noted in the proposed rule, gives them access to nearly free coverage. The primary beneficiaries in DC would be low-income immigrants subject to the 5-year bar. Without the bar, a District resident in this income range would be Medicaid-eligible and not APTC-eligible. The 5-year bar only applies to immigrants – a vulnerable and hard to reach population. Due to the prior Administration’s immigration policies, including the public charge rule, we and our navigators and community partners found it even more difficult to reach and enroll these residents. The proposed SEP would allow us to work year-round to get these residents enrolled in health insurance.

HBX also supports the proposal to make this SEP permanent, even beyond 2022 when the enhanced APTC benefits under the American Rescue Plan Act (ARPA) are currently set to expire. HBX agrees with the rationale outlined in the proposed rule - that this low-income population is the hardest to reach and the most in need of a year-round enrollment opportunity. Additionally, even if ARPA were not extended, the amounts this population would have to pay toward coverage would remain low, and they would still be eligible for the highest level of cost-sharing reduction (94% AV). Access to low-cost coverage (although not as low as under ARPA) will help keep this population enrolled even beyond 2022.

While HBX supports the proposal overall, we oppose the proposed metal level restriction. Consistent with our comments to the Market Stabilization Rule, the 2019 Notice of Benefit and Payment Parameters (NBPP), and the 2021 NBPP, we believe metal level restrictions of any kind are arbitrary and capricious and inconsistent with the statutory language of the ACA. The statute requires marketplace SEPs to be consistent with existing SEPs under HIPAA and metal level restrictions are contrary to longstanding HIPAA SEP rights.¹ HIPAA requires that SEP-eligible individuals have the same election rights as regular enrollees, including the right to select from all plans. Individuals and their dependents should be permitted to select plans to ensure their plan is affordable and otherwise meets their needs based on their circumstances. For example, although individuals and their dependents could enroll in the Second Lowest Cost Silver Plan (SLCSP) with very low premiums, they may prefer to enroll in a Bronze plan, with an even lower premium as low as \$2/month in 2021 in DC Health Link.

HBX has not seen evidence that enrollees who experience an increase in income, and become ineligible for plans with very low premiums, drop coverage once their monthly premiums increase. Instead, customers switch to bronze plans.

Given the number of SEPs we have implemented for our residents, HBX closely monitors SEP enrollment patterns. We have not seen evidence of adverse selection. We also coordinate closely with our carrier partners, who have not reported patterns of adverse selection based on claims information.

¹ Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (Aug. 21, 1996), Section 2701(f).

We use age as a proxy for health to help identify adverse selection. Looking at 2020 SEPs (we opened our system to open enrollment status when COVID-19 hit) and 2019 SEPs compared to Open Enrollment (OE) 2020 and 2019, the SEP age-mix is actually better than age mix during OE.

AGE GROUP	OE 2019	SEP 2019	OE 2020	SEP 2020
< 18	8%	12%	10%	10%
18-25	8%	8%	10%	9%
26-34	42%	44%	39%	44%
35-44	21%	18%	20%	18%
45-54	12%	10%	11%	10%
55-64	8%	8%	9%	8%
65+	1%	0%	1%	1%
TOTAL	100%	100%	100%	100%

Given that CMS restricted other SEPs, CMS should have data that shows adverse selection when SEPs are unrestricted. In other words, in the FFM, how does age mix compare between the restricted SEPs and unrestricted SEPs as compared to OE. Absent evidence, the restriction is arbitrary and capricious.

Finally, if CMS moves forward with restricting the SEP to one metal level, we ask that CMS provide SBMs with flexibility not to restrict the metal level for this SEP. Changing the IT system to restrict access in the individual marketplace, for an SEP that applies to a small subset of enrollees, will require significant IT design changes and will be costly. It also would be bad public policy, depriving residents of the ability to choose a plan that works best for them and their budgets.

Separate Invoicing for Non-Hyde Abortion Services - 45 C.F.R. § 156.280(e)

HBX supports the proposal to reverse the prior Administration’s change to 45 C.F.R. §156.280(e). The prior Administration’s regulatory change was unreasonable and beyond CMS’ legal authority. The prior Administration adopted a practice that is contrary to insurance premium billing practices and inconsistent with section 1303 of the ACA. It would have created new unnecessary costs that would be passed on to consumers through higher premiums, created confusion for insured people, and caused women to lose abortion services coverage or coverage altogether. We strongly opposed the prior Administration’s action.

When the prior Administration proposed the change, CMS acknowledged in the preamble to the proposed Program Integrity rule that the statute did “not specify the method a QHP issuer must use to comply with the separate payment requirement under section 1303(b)(2)(B)(i).”² However, there is statutory text that directly answers the question of whether monthly notices can be sent. Section 1303(b)(3) of the ACA directs how customers are to receive information regarding individual market qualified health plans that provide non-Hyde abortion services. Such carrier or exchange notifications can only provide information “with respect to the total amount of the combined payments for [non-Hyde abortion services] and other services covered by the plan.” The 2019 change to 45 C.F.R. §156.280(e) directly conflicts with this statutory text because it requires issuers to separately notify the customer on a monthly basis of the non-Hyde services related portion of the premium. Therefore, when reading section 1303 as a whole, a regulatory requirement that issuers must send separate invoices, or separate notifications related to non-Hyde abortion services, is in excess of CMS’s statutory authority and thus unlawful.³

Additionally, the prior Administration’s change was not reasonable. It contradicted well-established industry practice – one bill for the entire premium for a set period, e.g., monthly, quarterly, semi-annually, or annually. This is the case for health, auto, homeowners, and liability insurance policies. Billing systems for insurance are set up to produce one combined bill and generate additional invoices only if there is a late payment or a change to the policy, like adding dependents or new employees. Even if there are riders to a policy, the policyholder receives one bill, not separate bills in separate envelopes, as the 2019 regulatory change required. Under the prior Administration, CMS did not offer any examples where the new approach is used for other types of insurance billing. The agency failed to support the change with evidence that the approach is reasonable. Such an unreasonable requirement is arbitrary and capricious and are therefore unlawful.

The regulatory change was also completely unnecessary to achieve the congressional objective of segregating funds and ensuring no federal funds are used for non-Hyde abortion services. It was a solution for a non-existent problem. For the 5 years that preceded the change, issuers had been executing the CMS-approved methods⁴ of achieving Congress’s intent of having issuers segregate these funds, but without the severe negative consequences described below.

The new unnecessary costs for issuers would have been passed along to consumers through premium increases. Issuers would have to redesign their billing systems for a small portion of their business – individual exchange marketplaces. This means expensive IT changes, creating and operating a billing system only for individual marketplaces and not for products sold in any other market. There would also have to be changes to operations – invoice processing, collections, customer service support, EDI transactions with marketplaces, etc. There would also

² Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Notice of Proposed Rulemaking, “Patient Protection and Affordable Care Act; Exchange Program Integrity” 83 Fed. Reg. 56,015, 56,022 (Nov. 9, 2018).

³ 5 U.S.C § 706.

⁴ Centers for Medicare & Medicaid Services, “CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act,” (Oct. 6, 2017), <https://www.cms.gov/CCIIO/Resources/RegulationsandGuidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf> .

have been new administrative costs of mailing separate bills, in separate envelopes, and collecting separate payment (even if combined payment is accepted). None of these changes are cost-free, and costs would have been passed onto consumers through higher premiums.

According to a report by the Kaiser Family Foundation, at highest risk for premium increases, due to increased costs for IT and new operations, are people who live in California, New York, Oregon, and Washington.⁵ These states require abortion services to be covered by issuers.⁶ Also at high risk are people who live in states where abortion coverage is not banned and is available through marketplaces.⁷ These states include Alaska, Colorado, Connecticut, Hawaii, Maine, Maryland, Massachusetts, Montana, New Hampshire, New Jersey, Rhode Island, Vermont and the District of Columbia.⁸

There was also substantial risk that some issuers would not want to build new IT billing and operations systems for a small book of business. Those issuers would either leave marketplaces or drop coverage for medical services related to abortion procedures. People at highest risk of losing abortion services live in the District of Columbia and 12 states that do not require abortion coverage but health insurance covering abortion services is currently available.⁹ If issuers dropped coverage for abortion, thousands of District residents and millions of women and men across the country would be impacted. Cost for such medical procedures would be shifted from insurance companies to women and families.

The prior Administration's interpretation was so egregious that multiple federal courts issued injunctions in 2020.¹⁰

In summary, we appreciate that CMS is now proposing to reverse the prior Administration's unlawful interpretation and public policy that would have hurt women and their families. We strongly support the proposed change to 45 C.F.R. § 156.280(e) to revert back to the language prior to the 2019 Program Integrity Rule.

Direct Enrollment and Web Brokers - 45 C.F.R. §§155.221(j)

HBX strongly supports CMS's proposal to withdraw the prior Administration's rules on direct enrollment and web brokers. The prior Administration's interpretation of the Affordable Care Act's (ACA) exchange marketplace requirements was not reasonable, and was therefore unlawful.¹¹ The prior Administration's proposals put consumers at risk and endangered the stability of ACA insurance markets. HBX strongly opposed the regulatory changes then and supports CMS's current proposal to withdraw those.

⁵ A. Salganicoff and L. Sobel, "Abortion Coverage in the ACA Marketplace Plans: The Impact of Proposed Rules for Consumers, Insurers and Regulators," Kaiser Family Foundation, Issue Brief (Dec. 2018), <http://files.kff.org/attachment/Issue-Brief-Abortion-Coverage-in-the-ACA-Marketplace-Plans>.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Planned Parenthood of Maryland, Inc. v. Azar*, No. CV CCB-20-00361, 2020 WL 3893241 (D. Md. July 10, 2020); *California v. U.S. Dep't of Health & Hum. Servs.*, 473 F. Supp. 3d 992, 1002 (N.D. Cal. 2020).

¹¹ 5 U.S.C § 706.

The prior Administration's regulatory changes were not a reasonable interpretation of the statute. The ACA establishes standards for exchanges to facilitate enrollment into qualified health plans (QHPs). In 2020, the prior Administration re-interpreted these provisions to include a return to pre-ACA shopping and enrollment approaches with direct enrollment and web-based brokers, functionally equivalent to eliminating public ACA exchanges. It was not a reasonable interpretation to return shopping and enrollment to pre-ACA days and to get rid of ACA public exchanges. The prior Administration's proposed approach was also contrary to the ACA's no wrong door policy for Medicaid and subsidy programs. It ignored this requirement and consequently was 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 prior Administration did not have authority to do. In addition, the prior Administration did not have authority to delegate these essential government functions performed by public marketplace exchanges.

Consumers are better served through ACA exchange marketplaces

The prior Administration asserted that direct enrollment by insurers would benefit consumers through an enhanced and better shopping experience. However, they did not offer any evidence to support the assertion. Additionally, while the prior Administration claimed to believe in transparency and consumer empowerment, the direct enrollment regulations they finalized would have eviscerated 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, direct enrollment deprives consumers of 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.¹² 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.

¹² 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.

ACA state-based marketplaces 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.

The prior Administration's Direct Enrollment and Web-based Broker approach opened the 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, and exposing consumers to huge financial and medical risk for unpaid medical bills.¹³ CMS in fact has published alerts to help consumers to protect themselves.¹⁴ 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.¹⁵

The regulatory changes made by the prior Administration would have made the current problem worse. First, without a public exchange shopping and enrollment website, there is no simple way like 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.

When the prior Administration was considering changes, we also expressed concerns in our comments about privacy. Consumers would be at increased risk of having their sensitive personally identifiable information (PII) mishandled or misused by a direct enrollment entity. In the Direct Enrollment Marketplace model finalized by the prior Administration, consumers would have had no choice but to enroll through private entities and would have been forced to share sensitive PII, such as social security numbers, birthdates, 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 held 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 would be multiplied by the fact that downstream entities beyond the Direct Enrollment Marketplace, which CMS does not propose to directly oversee, would also have had access to consumers' personal information including PII.

Given all the risk, and in this case the prior Administration's unlawful interpretation of the ACA, we strongly support the proposal to withdraw the prior Administration's regulations on web-based brokers and direct enrollment.

¹³ See e.g. "California Takes Down 10 Fake Obamacare Websites", Reuters, November 14, 2013, available at <https://cn.reuters.com/article/instant-article/idUSBRE9AD17K20131114>

¹⁴ See <https://www.healthcare.gov/how-can-i-protect-myself-from-fraud-in-the-health-insurance-marketplace/>

¹⁵ "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>

1332 Waivers - 31 CFR Part 33 and 45 CFR Part 155)

HBX supports the proposed elimination of the prior Administration's interpretation of section 1332 and we support the new interpretation and regulatory text which tracks the 2015 guidance on section 1332 waivers. HBX strongly opposed the prior Administration's action to incorporate by reference their 2018 "guidance" on Section 1332 of the ACA into a regulation. The prior Administration's policy harmed consumers and contradicted the statute. Furthermore, using a reference rather than crafting concrete regulatory language circumvents the intent of the APA. These actions were part of the prior Administration's efforts 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 prior Administration attempted to undercut these statutory requirements in several ways. The prior Administration issued "guidance" encouraging states to submit waiver proposals that would weaken protections for people with preexisting conditions, cut premium help for older people and consumers with low incomes, and increase out-of-pocket costs.

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 prior Administration asserted that a state could meet these guardrails by showing that residents would have access to affordable and comprehensive coverage. By interpreting "provide coverage" as merely access to coverage as opposed to actual enrollment, the prior Administration's interpretation conflicts with the statute. HBX's full comments letter in opposition to the 2018 guidance, which detailed the harm to consumers and the contravention of the statute, is attached to these comments.

Furthermore, the prior Administration's approach of incorporating guidance was a highly unusual process. The 2018 "guidance" was not an actual rule making. There was no proposed or final regulation. Building on a highly unusual approach, in Part 1 of the 2022 Payment Notice final rule, the prior Administration finalized a regulation that has no substantive language but instead referenced 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.

User Fees 45 C.F.R. §156.50

HBX supports the proposed increase to the federal marketplace (FFM) user fee from 2.25 percent, as finalized by the prior Administration in Part 1 of the 2022 Payment Notice final rule, to 2.75 percent. The proposed rule would also increase the user fee for state-based marketplaces

that use the federal platform (SBE-FPs) from 1.75 percent, as finalized by the prior Administration in Part 1 of the 2022 Payment Notice final rule, to 2.25 percent.

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 prior Administration asserted that a lower user fee would be sufficient to fund current federal marketplace activities. However, the federal marketplace activities at that time were inadequate as evidenced by rising uninsured rates especially in states using healthcare.gov, on-going losses of coverage in healthcare.gov states¹⁶, 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 2019.¹⁷ According to a Kaiser Family Foundation analysis, communities of 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.¹⁸

Additionally, the prior Administration stopped nearly all marketing and outreach and slashed funding for Navigators, both of which are core marketplace functions funded by user fees. Before 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 needs 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 by the prior Administration.

This proposed rule indicates that the increased user fee would be dedicated to the critical areas of consumer education and outreach, plan review, and management of the eligibility/enrollment process. These are the functions that state-based marketplaces, such as HBX, invest in and support through our budgets and assessments. HBX supports CMS's proposed change to user fees.

Conclusion

The proposed changes support market-stabilizing solutions, flexibility for states, and policies that help people obtain affordable, quality health insurance. We support CMS's proposed changes. Thank you for considering our comments on issues that will directly impact District residents and the continued operations of our marketplaces. We look forward to working with you on these

¹⁶ 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>

¹⁷ "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/>.

¹⁸ "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/>.

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



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 guidance¹ 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.

¹ 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.²

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 letter³, 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

² 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.

³ 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.

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 read 'Mila Kofman', with a long horizontal flourish extending to the right.

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority