



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). 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



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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