



December 21, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9937-P
P.O. 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 - CMS-9937-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments below. HBX is an independent instrumentality (private-public partnership) created by the District Council to implement the State-based marketplace (SBM) under the Affordable Care Act (ACA) in the District of Columbia. The marketplace, called DC Health Link (DCHealthLink.com), enables individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance.

HBX strongly supports the Centers for Medicare & Medicaid Services (CMS) continued work to strengthen the Affordable Care Act. HBX would like to express specific support for the following:

- §155.430 relating to terminations of marketplace enrollment through issuers or marketplaces;
- §156.270 providing clarification on grace periods for advance premium tax credit (APTC) consumers;
- the proposed clarifications to §155.505 *et seq.* on eligibility appeals;
- §155.400 relating to the Federally-facilitated marketplace's (FFM's) binder payment policy;
- §155.625 permanently authorizing SBMs to use the HHS exemption process. HBX like other SBMs relies on existing federal services for exemptions;
- §147.107 promoting continuity of coverage for small businesses; and
- §155.225 providing SBMs flexibility on data collection requirements for Certified Application Counselors.

In addition, we provide detailed comments to the proposed rules for navigators, notices to employers, verifications, open enrollment periods, special enrollment periods, web-brokers/issuer direct enrollment, and the user fee for the FFM.

Navigator Program Standards (45 C.F.R. §155.210)

The proposed standard would eliminate SBM flexibility to determine the duties for Navigators. The proposal would prohibit SBMs from continuing the proven and effective consumer assistance implemented by SBMs during the last three years. If this is not the intent, clarification is necessary. HBX



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

strongly supports flexibility for states to continue effective approaches based on local state-based experience.

CMS' proposal would significantly expand Navigator duties and require navigators to assist individuals with eligibility appeals, applications for exemptions, certain federal tax provisions, as well as to assist with health literacy. In addition, these expanded duties include potential tax advice through tax forms such as 1095As.

In the District of Columbia, we have implemented an approach to consumer assistance that leverages experts from different types of community based consumer advocacy and patient advocacy organizations. Leveraging the expertise of Navigators, In Person Assisters, Certified Application Counselors, and DC Health Link Brokers has resulted in successful consumer assistance. We also partner with business associations and sister agencies. HBX has partnered with tax clinics to provide information on ACA related tax information, including information on the individual responsibility requirement and tax credits.

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 expert brokers for help choosing among the 26 different individual qualified health plans we offer. Brokers also provide on-going support, helping people to understand and use their health insurance post enrollment.

The CMS proposal seeks to replace effective on-the-ground experts who have decades of experience in providing help to consumers. There is no compelling public policy reason to disrupt what now works well for consumers in favor of duplicating and replacing existing on-the-ground expertise. Furthermore, HBX has strong concerns that few or no organizations would qualify to serve as Navigators if Navigators had to perform all functions that are currently performed by tax experts, legal services, consumer and patient advocate groups, brokers and assisters, and government agencies. Finally, because Navigator programs are an ACA requirement for SBMs, compelling states to create new complex programs in order to maintain SBM status three years into the program is problematic.

HBX strongly supports flexibility to allow SBMs to continue successful consumer assistance and opposes the proposed new requirements for Navigators. HBX does not have a position on the proposed requirements as they would apply to the FFM.

Eligibility Process – (45 C.F.R. §155.310)

HBX supports marketplace flexibility related to employer notification under §155.310. Under this proposed rule, marketplaces are required to notify employers if one of their employees is eligible for advance premium tax credit and has enrolled in marketplace coverage. CMS also proposed to provide marketplaces with the option to notify employers on an employee-by-employee basis as individual eligibility determinations are made or grouped by employer based on employee enrollment in QHP coverage. To require grouping notices would create IT and business implementation resource issues adding cost to our ongoing operations. Therefore, HBX supports SBM flexibility to choose between these options.

Verification Process Related to Eligibility for Insurance Affordability Programs 45 C.F.R. §155.320

CMS proposed to allow SBMs the flexibility until 2018 to develop an alternative process to verify whether an applicant eligible for APTC has an offer of affordable employer sponsored insurance. That alternative process would be required where a primary process for verification using three data sources checking on employer sponsored insurance was not available.

HBX urges that this flexibility be permanent rather than sunseting in 2017. State flexibility to innovate over time on this complex question is critical to finding a verification method that works best for the consumer especially because the integrity of data varies by source and by state.

Additionally, after 2017, CMS limits states to a single alternative verification method where the primary process for verification using three data sources checking on employer sponsored insurance is not available. That method is employer sampling.

HBX urges state flexibility to develop other permanent verification methods. In the District, employer sampling is not a meaningful option to determine whether an applicant eligible for APTC has an offer of affordable employer sponsored insurance. Only a small portion of our population receives APTC (around eight percent of our individual market exchange population). Of that population, based on a survey of customers, many are self-employed or do not have wage income. HBX sampling of a small number of employers would not be useful. Therefore, we support state flexibility.

Initial and Annual Open Enrollment Periods (45 C.F.R. §155.410)

HBX supports aligning open enrollment for the individual marketplace with open enrollment periods that large employers have, generally late fall. In the short term, however, HBX recommends an open enrollment period of November 15 to January 31. This recommendation is based on specific consumer issues we have seen. For example, a person is 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 critical especially given the tax penalties.

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

CMS is asking for information in response to “concerns that these special enrollment periods may be subject to abuse.” We do not have evidence of abuse. To the contrary, special enrollment rights are critical to District residents.

The exceptional circumstances provision in §155.420(d)(9) has enabled HBX to address the needs of customers who have lost access to health insurance due to life events not specifically addressed in other special enrollment provisions. For example, people lose access to coverage due to domestic abuse. In DC, some of our customers enter or terminate a domestic partnership or civil union, consequently needing new coverage.

The District’s exceptional circumstances special enrollment standards are developed through a transparent public consensus process, with input from health insurance issuers, consumers groups, brokers, providers, and other stakeholders. The formal stakeholder process includes HBX staff monitoring and identifying requests for special enrollment where a consumer does not meet existing criteria. HBX staff also review exceptional circumstances that states adopt to foresee and prevent

obstacles for DC's residents in the future. Based on local need and action by other states, the information is presented to the Standing Advisory Board for consideration. The Standing Advisory Board includes consumers, brokers, small businesses, providers, and issuers. The Standing Advisory Board reviews the SEP proposals, receives public input, and then votes. To date, SEPs recommended for adoption by the Standing Advisory Board have been through unanimous votes. The recommendation then goes to the HBX Executive Board and after additional public input, the Board votes on SEPs.

This process ensures clarity, consistency, and compliance with applicable law while also assuring that unnecessary (and sometimes discriminatory) barriers to coverage are removed.

Special enrollment opportunities, including exceptional circumstances, are essential to ensure that consumers are able to get and keep health insurance as their life circumstance changes over time. HBX strongly urges CMS to maintain state flexibility and to allow SBMs to address the local needs of our customers.

Web Brokers/Issuer direct enrollment in QHPs

HBX is strongly opposed to these proposals as they apply to SBMs for several reasons. When HBX looked at best ways to provide consumer assistance and maximize enrollment opportunities, HBX staff met with a large web-based broker. Ultimately, the web-based broker was not a fit. The web-based broker could not provide any information related to issue resolution, complaints, or any quality elements related to customer service. Upon discussions with local brokers, HBX staff learned that in fact, the quality of service would not meet our current standards applicable for example to our contact center. The local broker community in the District provides exceptional service to 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 importantly the local broker community.

HBX would also oppose direct enrollment by issuers. With the purchasing power of thousands, 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 arguing 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 136 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.

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

FFM User Fee

HBX as an SBM supports a strong federally facilitated marketplace in states that do not have an SBM. In part, whether the FFM continues on its successful path in covering the uninsured depends on its resources. Specifically, the FFM needs to continue its strong marketing and enrollment efforts.

SBMs and the FFM have achieved strong enrollment over the first three open enrollment periods. That enrollment has been the combined result of effective marketing, well designed outreach programs, and partnerships with key groups that have helped marketplaces reach target populations. Finding the remaining uninsured populations is more difficult and that is why funding for marketing and enrollment efforts is critical. HBX's outreach efforts have become more localized and even more targeted since the first open enrollment. For example, although our highest enrollment is 26 to 34 year olds (41%), this age group also still has high uninsured rates and remains a key target population. Outreach at movie openings such as Hunger Games and Star Wars and cafe crawls in the late hours are aimed at educating and enrolling this age group. For the FFM to continue strong success, sufficient budget focus on marketing is necessary.

Also, the regulations should promote and support future state partnerships as a way to reach the hardest to reach uninsured populations because states are in the strongest position to know their populations. It is not clear whether the .5% of FFM fee is sufficient to perform partnership functions. Insufficient funding would have the unintended effect of discouraging states from becoming partnership states.

Conclusion

HBX supports state-based solutions and flexibility for SBMs. We appreciate the strong partnership we have with CMS and other federal agencies. Thank you for considering our feedback to regulations that will directly impact SBMs.

Sincerely,



Mila Kofman
Executive Director
DC Health Benefit Exchange Authority