DC Health Benefit Exchange Authority

November 9, 2015

U.S. Department of Health & Human Services
Office for Civil Rights
Attn: 1557 NPRM (RIN 0945-AA02)
Hubert H. Humphrey Building, Room 509F
200 Independence Ave. SW
Washington, DC 20201

Re: Nondiscrimination in Health Programs and Activities – RIN 0945-AA02

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments. HBX is an independent instrumentality (private-public partnership) created by the D.C. Council to implement the Affordable Care Act (ACA) in the District of Columbia. HBX is responsible for implementing a state-based on-line health insurance marketplace under the ACA.

The District of Columbia has been a leader protecting civil rights of all residents and has specifically addressed discrimination that relates to gender identity and expression. We strongly support your efforts to ensure that such protections are available to people living in every state.

Below are specific suggestions and information on potential impact of some of the proposed provisions on HBX.

Assurance (45 C.F.R. §92.5)

The proposed rule requires state-based marketplaces (SBMs) to submit a one-time assurance of compliance with these provisions, at the time of seeking approval to operate an SBM or, for existing SBMs, at a time specified by the Office for Civil Rights (OCR). We support this provision as drafted, requiring a one-time assurance.

Designation of responsible employee and adoption of grievance process (45 C.F.R. §92.7)

The proposed rule requires a grievance process for nondiscrimination claims. HBX strongly encourages OCR to retain state flexibility in this provision, allowing covered entities to use either existing grievance processes (for example use existing HBX grievance processes or processes existing within other District government agencies) or develop new processes that best suit the needs of the populations being served. The District has been a leader in protecting civil rights and vulnerable populations and has processes and proven expertise in place. Additionally, even if the existing processes could not be utilized for these enhanced federal protections, flexibility to partner with other agencies subject to the new protections, would result in efficiencies and a stronger process for consumers.

Notice Requirements (45 C.F.R. §92.8)

It is important to notify consumers of rights and protections. Research shows that depending on the length, wording, and type of notice, consumers may not read an important notice. We ask that the proposed notice requirement be limited in scope and not interfere with the purpose of certain types of documents. We have strong concerns about the proposed notice requirement and ask OCR or other appropriate federal agency to conduct focus group or other testing to ensure the notice effectively conveys this important information. Focus group testing should include all required disclosures in the notices that SBMs are required to provide under 45 C.F.R. §155.230. A model notice provided by OCR based on consumer testing should be made available for SBM use.

Under applicable federal and District law, SBM notices are required to include: 1) a full page of language access taglines; 2) the substantive notice itself (for example a denial of a special enrollment request), including citations to relevant regulations; 3) appeal rights, when applicable; and 4) contact information for available customer service resources. In some cases, the notice sent to consumers is more than 10 pages in length (see Attached example of a 16 page notice). To require additional information to already lengthy notices, or additional notices to consumer communications, will not improve consumer knowledge of their rights, but rather may increase consumer confusion and frustration. Therefore, we ask that OCR limit where this notice must appear with the aim of ensuring real consumer empowerment. In the interim, an SBM should be considered as meeting the notice requirements if the State provides the notice of nondiscrimination rights on the on-line marketplace website and the application for coverage.

HBX opposes a requirement for notice in documents like postcards or tri-fold brochures, which provide limited information and are not well suited to disclosures of civil rights. In part, communications via postcards, tri-folds, and other limited forms of communication are beneficial because they provide limited essential information for consumers. Their goal is to drive consumers to other sources where the notice would exist, such as the marketplace website or application. The proposed notice, with the taglines, could not be incorporated in these types of brief communications due to its length and would have the unintended consequence of preventing HBX from providing these brief, effective communications to consumers.

Presently HBX is providing seven (7) language access taglines, increasing to 15 in the fourth open enrollment period. HBX supports flexibility to choose between providing taglines in the top 15 languages spoken nationally or the top 15 languages spoken in the state where the SBM is located. This option would enable HBX to determine which standard would be most beneficial to the population we serve in the District. For example, the District has a large Amharic speaking population. A national top 15 languages likely would not include Amharic. In addition, marketplaces are subject to language access requirements under 45 C.F.R. §155.205. Thus we ask that OCR work to ensure consistency across regulations. To that end, HBX requests that OCR clarify that compliance with the requirements set forth at 45 C.F.R. §155.205 will satisfy the requirement to provide language access taglines under the final rule.

HBX requests that the final rule provide covered entities with time to implement these requirements. Depending on the final rule, HBX may need to modify the on-line marketplace – some IT modifications can take time. Also, depending on how the notice requirement is structured, there may be an additional budget impact that cannot be funded out of current revenue. We appreciate any flexibility that enables us to comply in a cost effective and consumer protective manner.

Specific Discriminatory Actions Prohibited (45 C.F.R. §92.101(b)

Age rating

HBX supports the extension of the nondiscrimination provisions under the Age Act through this proposed rule. HBX requests that OCR clarify that the employer contribution models listed below would continue to be permissible under the age discrimination rules. Specifically, HBX SHOP currently uses the "Reference Plan with Percent-of-Premium" model for small businesses. For Members of Congress and their designated staff, HBX uses the "Percent-of-Premium with Cap on Employer Contribution" model as required by Office of Personnel (OPM) statutes and regulations. Specifically, §8906 of Title 5, codified at 5 C.F.R. §890.501(a) governs federal government premium contributions for federal employees, including members of Congress and designated staff. In October of 2013OPM designated the HBX SHOP as the marketplace for members and designated staff of the United States Congress to access health insurance with an employer contribution. Absent confirmation that these approaches would be permissible under the new final rule, HBX would be exposed to significant risk, jeopardizing HBX's ability to continue to serve Congress consistent with OPM requirements.

Details:

Reference Plan with Percent-of-Premium

The employer contribution is based on the reference plan and is a percentage of the premium for the employee based on the employee's age. The employer selects a reference plan. Employees can select a qualified health plan other than the reference plan if the employer offers choice. The employer pays the same percentage of premium for all employees; however the actual dollar amount of the employer contribution varies based on the reference plan premium which is based on the employee's age. This difference results from application of the age rating bands as permissible under the ACA. The actual dollar amount of the employer's contribution to older employees will be higher than to younger employees but the percentage of premium is equal across all ages. If an employee chooses to enroll in a different plan, other than the reference plan, the employee can use the same employer contribution dollar amount and then pay/save the difference in the underlying age-based premiums. This contribution model is currently offered to employers in the HBX SHOP.

Additionally, in response to requests from brokers and employers, HBX is considering adding additional employer contribution choice -- "reference plan fixed employee cost" – described below. We request confirmation from OCR that such an employer contribution approach would be permissible under the final rule.

Reference Plan Fixed Employee Cost

The employer sets a flat dollar cost that any employee would pay. All employees, regardless of age, would pay the same amount to enroll in the reference plan. The employer pays a higher percentage of the premium for older employees than younger employees, while the actual dollar amount of the employee's cost is the same to each employee. If an employee chooses to enroll in a different plan, other than the reference plan, the employee pays/saves the difference in the underlying age-based premiums.

Protections against discrimination on the basis of sex (45 C.F.R. §§92.206 and 207)

The District of Columbia has been a leader in addressing discrimination related to gender identity and expression. Working with HBX, the Department of Insurance, Securities and Banking (DISB) issued guidance to clarify that health insurance carriers are prohibited from discriminating on the basis of gender identity or expression and specified that "exclusionary clauses that discriminate on the basis of 'gender identity or expression' are *prima facie* prohibited…." DISB also clarified that "attempts by companies to limit or deny medically necessary treatments for gender dysphoria, including gender reassignment surgeries" would be

viewed as discriminatory. District of Columbia Department of Insurance Securities and Banking, Bulletin 13-IB-01-30/15 Revised (February 27, 2014).

HBX strongly supports the proposed provisions. Research shows that the transgender community has been subject to discrimination in health insurance benefits – coverage being denied that is not denied to others. We believe that these provisions are a critical step toward protecting every person's civil rights and to prohibiting insurance practices that create barriers to accessing medical care.[1] In addition, HBX strongly supports the proposal to require covered entities to treat individuals consistent with their gender identity. We believe that the clarification that entities may not deny or limit health services on the basis of gender identity or sex assigned at birth is essential to ensure that all people have access to appropriate medical care.

HBX also requests and strongly supports a clarification in the final rule that covered entities are prohibited from discriminating on the basis of sex, as relates to sexual orientation. The District of Columbia has protections in place to prevent health insurance carriers from discriminating on the basis of sexual orientation, as well as on the basis of gender identity and expression (as addressed above). We fully support these provisions as they exist in the District of Columbia and believe that these protections should be incorporated in the OCR rule to clearly prohibit discrimination and to protect all people's civil rights.

Notably, HBX has been working to eliminate questions related to gender in the DC Health Link application for health coverage with the aim of reducing the possibility of discrimination on the basis of sex, including but not limited to gender identity and expression. We believe that these types of questions have no legitimate use in the application and enrollment process and believe that the removal of these questions will help eliminate barriers that some consumers face in accessing necessary medical care. We fully support OCR's proposed rule to extend protections to these populations, and HBX is committed to ensuring all of our customers are treated equally, regardless of sex, gender identity, gender expression, and sexual orientation.

Enforcement Mechanisms (45 C.F.R. §92.301)

Private Right of Action

HBX has significant concerns about this section of the proposed rule and opposes inclusion of this provision as written in the final rule. It provides, in part,

> an individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient or State-based Marketplace is found or transacts business.

This provision would mean that any customer covered through the small business marketplace could bring a discrimination action against HBX *in any federal court where the individual resides* or in the United States District Court for the District of Columbia.

In October of 2013, OPM designated the HBX SHOP as the marketplace for members and designated staff of the United States Congress to access health insurance with an employer contribution. Not only does HBX

[1] See "Moving the Needle: The Impact of the Affordable Care Act on LGBT Communities," K. Baker, L. Durso, and A. Cray, Center for American Progress, November 2014. Available at https://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdf.

provide access to health coverage for members of Congress and their District of Columbia and other local staff, but HBX also serves Congressional staff in each member's district offices across all 50 states and the US Territories.

The District would be prejudiced by having to litigate discrimination cases in every State and Territory of the United States. The financial and organizational pressures this proposed rule would have on the operations of the District of Columbia, and specifically on the Office of Attorney General, would be immense and, we fear, ultimately, unmanageable. To require the District's lawyers to travel and litigate across the country and in the Territories will be extraordinarily expensive and time consuming.

HBX opposes this provision of the proposed rule and recommends that Section 92.302 be amended to allow suits only in the state where the marketplace is located. This amendment would mean that members of Congress and their staff and employees of small businesses covered through DC Health Link would file any claims involving HBX in the United States District Court for the District of Columbia. That court, which regularly hears cases involving litigants from all over the country (and the world), is especially well-equipped to provide full and fair consideration of any matter brought before it. HBX will also include in its grievance procedures means through which potential litigants will be able to submit complaints and resolve issues remotely. This approach will ensure legal protection to anyone wishing to pursue a claim of discrimination against HBX, while minimizing the approach of the proposed rule that would force a state to incur extraordinary costs of having to litigate in all states and territories.

Data Collection

HBX has concerns over new data collection requirements outlined in the proposed rule. HBX requests that OCR consider the extensive existing data requirements applicable to SBMs and the costs of additional data requirements that an SBM would be incurring (while continuing efforts to be self-sustaining). As an SBM, HBX is required to comply with extensive data collection and reporting requirements pursuant to Department of Health & Human Services (HHS) and Internal Revenue Service (IRS) regulations. IT systems developed using federal grants were designed to comply with these extensive requirements. Changes to the IT system are costly and absent federal grants could create a significant financial burden. Currently, SBMs are required to submit three annual reports, one bi-annual report, one quarterly report, two monthly reports and additional weekly and daily reports to the federal government. There are different requirements depending on whether the reporting is to the IRS or to the Centers for Medicare & Medicaid Services (CMS). To meet these requirements SBMs collect extensive data. More extensive and new reporting requirements would create a considerable burden on our operations, IT build, and budget.

Thank you for your consideration of these comments.

Sincerely,

Mila Kofman, J.D.
Executive Director
DC Health Benefit Exchange Authority

Attachment: Sample Required Notice