



December 22, 2014

Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-9944-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016  
– CMS-9944-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority appreciates your consideration of our comments below.

#### State Flexibility

The DC Health Benefit Exchange Authority supports proposals that provide state-based exchanges (SBEs) with flexibility. Flexibility will better enable SBEs to function more efficiently and effectively and adapt to our local needs. For example, we support state flexibility to determine whether or not to accept credit card payments in SHOP, to determine whether to establish alternative enrollment hierarchies under §155.335, and whether to establish deadlines for the payment of the first month's premiums for small businesses to effectuate coverage under §155.400. We encourage HHS to provide additional flexibility where possible, such as determining special enrollment period effective dates in SHOP and defining when SHOPS can effectuate coverage under §155.727(k). States have made numerous operational and policy decisions, many of which have been developed in partnership with community stakeholders. It is critical to maintain the SBE flexibility to mitigate unintended consequences like having to pay for modifications to IT functions that have already been built. We strongly support the state flexibility HHS has set forth in these proposed rules and encourage HHS to continue to extend flexibility to SBEs in further rulemaking and guidance.

#### Definitions - §155.20

HHS proposed to amend the definitions "Applicant," "Qualified Employee," and "Enrollee." We seek clarification of the proposed definition of "enrollee." Currently, we determine the eligibility of the business owner for SHOP based on whether the business has at least one employee that is *eligible* for QHP coverage through SHOP, not whether an employee actually chooses to *enroll* in QHP coverage through SHOP. As proposed an "enrollee" includes the business owner or the dependent of a business owner enrolled in a QHP through the SHOP only if at least one employee chooses to *enroll* in a QHP through SHOP.

The proposed definition in this rule is inconsistent with current practice, so we ask that HHS modify this



definition to reflect current practice in SHOPS. Specifically, we urge HHS to clarify that the term “enrollee” includes a business owner enrolled in a QHP through the SHOP when at least one employee is *eligible* for coverage in a QHP through SHOP.

#### Annual Eligibility Redetermination - §155.335

HHS is considering setting an alternative reenrollment hierarchy in the Federally Facilitated Exchange (FFE) and offering consumers a choice of which reenrollment hierarchy to apply. For example, in the FFE, consumers could elect to be reenrolled into a low-cost plan rather than the plan the consumer selected at the time of enrollment. For SBEs, HHS is considering providing flexibility to SBEs to establish alternative reenrollment hierarchies. We strongly support providing the SBEs flexibility on these decisions.

Each marketplace has unique characteristics and may not benefit from the same re-enrollment approach. For DC Health Link, for example, a re-enrollment hierarchy in which premium is the determining factor would not make sense as this would presuppose that consumers are indifferent to the delivery model and carrier. If SBEs are required to use the FFE approach, consumers could have a disruption by being moved between our two largest carriers, Kaiser Permanente and CareFirst Blue Cross Blue Shield, which have two very different delivery and financing of care models. We do not believe such reenrollment options should be required in SBEs. Furthermore, requiring FFE type hierarchies would mean that states have to modify existing systems to create new IT functionality. Consequently, this proposal would require significant investments from states on functionality that would not be suitable for many District consumers.

States should be provided with the flexibility to determine whether alternative reenrollment hierarchies would be beneficial in a state-based marketplace, how to design new hierarchies, and when or if these would be implemented.

#### Enrollment of Qualified Individuals into QHPs - §155.400

HHS is considering setting payment deadlines for individual coverage through the FFE. HHS is considering several options, including a more restrictive option which would require payment by the effective date or the day before coverage becomes effective and a more flexible option that would allow for payment to be made a set number of days after the effective date of coverage (for example, 5, 10 or 30 days after the effective date of coverage). As proposed, these provisions would be limited to the FFE. SBEs would have the option to adopt their own policies requiring payment of the first month’s premium to effectuate coverage.

Although no deadlines are being proposed for the SBEs we recommend that states be allowed to set their own deadlines now and in the future. Regardless of whether HHS ultimately sets payment deadlines in the FFE, we strongly believe that states need flexibility to make these determinations based on their own markets.

#### Open Enrollment §155.410

HHS proposed that open enrollment for benefit years beginning on or after January 1, 2016 run from October 1 to December 15. We strongly support the policy of ending open enrollment prior to the start of the new plan year. However, we have concerns with the October 1 start date. We ask that the 2016 open enrollment period run from November 1 to December 15.

In our research there is no evidence to suggest that long open enrollment leads to better consumer decision making. On the contrary, looking at private and government employers, just the opposite seems to be true. According to the Society for Human Resource Management, open enrollment for employer sponsored health insurance is offered shortly before the beginning of the plan year and typically lasts for up to four weeks. For example, in 2014 open enrollment for District employees was November 10<sup>th</sup>- December 12<sup>th</sup>, Georgetown

University's open enrollment period was October 15<sup>th</sup>-November 14<sup>th</sup>, Eli Lilly's, October 21<sup>st</sup>- November 8<sup>th</sup> and Cleveland Clinic's, October 22<sup>nd</sup>-November 7<sup>th</sup>. In addition, federal employees have a 4 week open enrollment period. Even the Medicare program only provides beneficiaries approximately 7 weeks for open enrollment.

Many people who enroll in individual marketplace qualified health plans have had job-based coverage and are likely to be familiar with employer open enrollment. Consequently, closely aligning individual open enrollment with the group market will benefit our customers.

In addition, we have heard concerns voiced by carriers and insurance commissioners from around the county that there would be significant challenges to meeting the proposed October 1 open enrollment start date related to the rate and form filing and approval processes. Even after rates and forms have been approved, health insurance carriers need addition time to ensure all plan documents and online materials comply with the final approvals. Based on our own experience, we know that the October 1 start date for the 2014 plan year resulted in a very tight timeline for us and our carrier partners. This year's November 15 open enrollment made the process manageable.

For these reasons, we ask that the 2016 open enrollment period run from November 1 to December 15, approximately 6 weeks. This more closely aligns to open enrollment periods that have proven effective for private and public employers and Medicare.

#### Special Enrollment Periods - §155.420

HHS has proposed to modify special enrollment periods under §155.420. While we generally support the proposed modifications to the special enrollment provisions that would provide consumers with greater access to health insurance, we have some specific concerns about the proposed modifications.

Under §155.420(b)(2)(i) HHS proposed to modify one of the options for coverage effective dates in the case of birth, adoption, placement for adoption or placement in foster care. Under the existing regulations, marketplaces are permitted to provide these consumers the option to elect coverage to begin on the first day of the month following the triggering event, rather than on the date of event. Under the proposed regulations, HHS is eliminating this option and instead permitting a marketplace to allow a qualified individual to elect a coverage effective date in accordance with the regular effective dates set forth at §155.420(b)(1).

We strongly oppose this modification as it is contrary to our current practice and is less-consumer friendly. The change would lead to later effective dates than current policy, potentially forcing consumers to choose between either coverage starting on the date of triggering event or a substantial gap in coverage. In addition, changing the current policy option would require a significant IT modification which has not been included in our planning or budget. We urge no further change in this policy.

HHS also proposed to modify §155.420(c)(2) and (b)(2)(vi) to allow consumers to gain advance access to the special enrollment period due to a permanent relocation under section (d)(7). This proposed amendment would permit qualified individuals to request a special enrollment 60 days prior to the triggering event. We strongly support this proposed amendment which will allow an individual to maintain continuous coverage.

Under §155.420(d)(2)(i) HHS proposed to create a special enrollment period for situations where individuals have a court order requiring a qualified individual to cover a dependent or other individual. We treat court orders as an "exceptional circumstance" under section §155.420(d)(9) and support this special enrollment period. We would also support providing marketplaces with flexibility to provide effective dates that minimize gaps in coverage if the effected individual had health coverage at the time the court order was entered and a change was required by the order.

HHS also proposed a new (d)(2)(ii) which would create a special enrollment opportunity for individuals who experience the loss of a dependent or lose dependent status through legal separation, divorce, or death. We support allowing access to special enrollment periods in these circumstances, but ask that HHS further clarify that these rights extend to the termination of a domestic partnership or civil union in states where these legal relationships are recognized. The DC marketplace already treats this an “exceptional circumstance” under section 155.420(d)(9).

#### Standards for Establishing a SHOP - §155.705

HHS proposed to permit SHOPS to help employers administer COBRA and state continuation coverage (continuation coverage) by billing and collecting premiums directly from employees. As proposed, state-based SHOPS would have flexibility to determine whether to take on this role to assist in the administration of continuation coverage.

Changing the administration of continuation coverage is complex and each jurisdiction should have the ability to determine whether they want to administer these programs, whether it is practical to do so, and to assess the impact on small businesses in their marketplace. For these reasons, we ask that the state flexibility be maintained.

#### Enrollment Periods -§§155.725

HHS has proposed that new employees in SHOP have at least a 30 day enrollment period in §155.725(g). As proposed this enrollment period would end no sooner than 15 days prior to the date that any applicable waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible. We have concerns about this requirement. Such a change would result in an enrollment period for new employees that exceed 30 days, which could cause confusion for employers and employees, and result in later effectuation dates for coverage. In addition, the proposed change would require significant IT modifications which have not been included in our planning or budget.

HHS also proposed to require that the effective date of coverage for a newly qualified employee will always be on the first day of the month at §155.725(g)(2). We have concerns about this proposal as it is not consistent with current practice in our SHOP or with standard practice in the District’s small group market, could create gaps in coverage, and would be less consumer protective than our current practice. In the District, employers may elect coverage to be effective on the date of hire for new employees. This is by far the most popular option in our SHOP. This proposed change would eliminate this option, thus reducing employer and employee choice and resulting in gaps in coverage for employees. We ask that HHS grant states flexibility on this issue, so that SHOPS can determine whether mid-month effective dates should be available to employees, in collaboration with employers and carriers.

In §155.725(i) HHS proposed to permit SHOPS to automatically renew employers where the employer has not taken action to modify or terminate coverage, provided the employer is still eligible to participate in SHOP. We strongly support the state flexibility set forth in this provision, as this will allow SHOPS to determine whether this functionality would be beneficial for the employer community and whether this functionality would be feasible.

In addition, we seek clarification on what it means for an employer to become ineligible for coverage. For example, we encourage HHS to clarify that an employer be eligible for automatic renewal if the employer group falls below one non-owner FTE, similar to the rules that permit renewal of employers that increase to more than 50 employees. In addition we encourage HHS to clarify that marketplaces may renew an employer if the employer’s Employer Identification Number (EIN) changes provided the employer retains the same legal identity. Further clarifications on these issues would be helpful for SHOPS considering automatic employer renewals.

HHS also proposed to modify the effective dates for special enrollment periods under §155.725(j) to align effective dates with those set forth in §155.420. We strongly oppose these proposed changes. Such changes would dramatically change the rules for effectuation of coverage for employees and dependents with a qualifying special enrollment event. Such changes would require extensive modifications to our IT systems, which would be costly and require extensive staff and time commitments to achieve. In addition, these proposed changes are inconsistent with the large group market in the District and would be inconsistent with non-exchange coverage in other jurisdictions. We strongly support retaining the current rules, which are more closely aligned with the generally applicable special enrollment rules set forth at §146.117 and provide consistency with other markets. In addition, retention of the current rules will allow states with already established SHOPS to reduce the need to make substantial modifications to existing IT systems. In the alternative, we ask that states that have already established SHOPS be provided with the flexibility to continue current practice.

HHS has proposed to harmonize rolling enrollment in SHOP with the guaranteed availability provisions applicable in merged markets at §155.725(b). The District of Columbia has a hybrid merged individual and small group market for local rating purposes only. The merged risk pool does not change how carriers choose to offer plans in the individual or small group market, allows SHOP to have year round enrollment, and allows quarterly changes in rates for new business in SHOP. We assume that the proposed rules would not impact our hybrid merged market.

#### Termination of Coverage - §155.735

HHS proposed to shift certain notice requirements from QHP issuers to SHOPS. Specifically HHS proposed to require SHOPS to provide notice to enrollees if an enrollee is terminated due to non-payment of premiums under §155.735(g)(1) and notice to employers for termination due to non-payment of premiums or loss of the employer's eligibility under §155.736(g)(2). SHOPS would be required to provide these notices "promptly and without undue delay."

We have concerns about proposed requirements. This is a function carriers currently perform and their systems are built to automatically generate these notices. Nonetheless, if HHS moves forward to transfer this responsibility to SHOP marketplaces, we strongly encourage HHS to provide SHOPS adequate time to develop these notices, coordinate the notices with carriers, and implement the functionality necessary to provide these notices to employers and employees. We ask that HHS provide SHOPS at least until plan year 2017 to begin providing these notices. Additionally, if notices are required from SHOPS, we support the timing provisions set forth in these proposed regulation, which require SHOPS to provide these notices promptly and without undue delay. We believe this timing standard will require SHOPS to provide notices promptly while recognizing that different SHOPS may need to develop different timelines based on necessary coordination with carriers.

#### Transparency - §156-220

HHS solicited comments on the implementation of the transparency requirements under §156.130 including whether SBEs should be required to display the same information and the same format and manner as the FFE will display this data. We strongly support state flexibility on how transparency data is displayed, so that states can display this data in a manner and form that is most useful to their consumers, meet the unique needs of marketplaces, and is otherwise consistent with existing IT infrastructures. To provide such flexibility will minimize the potential financial impact on existing SBEs, while taking into account the information and format consumers seek.

We thank you for considering our comments and look forward to continuing to work with the federal government on implementation of the Affordable Care Act. We are available to discuss our comments and

would be happy to answer any questions.

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