



July 28, 2021

The Honorable Janet Yellen
 Secretary
 U.S. Department of the Treasury
 1500 Pennsylvania Avenue, NW
 Washington, DC 20220

The Honorable Chiquita Brooks-LaSure
 Administrator
 Centers for Medicare & Medicaid Services
 U.S. Department of Health and Human Services
 7500 Security Boulevard
 Baltimore, MD 21244

The Honorable Xavier Becerra
 Secretary
 U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Washington, DC 20201

Re: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule (CMS-9906-P)

Dear Secretary Yellen, Secretary Becerra and Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule (the “Improving Health Insurance Markets Proposed Rule”), issued by the Departments of Health and Human Services (“HHS”) and of the Treasury (collectively, the “Departments”).

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections

provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the federal government to make the best use of the knowledge and experience our patients and organizations offer in response to the proposed rule.

In March of 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

We recognize and appreciate the concrete steps the Administration has already taken, through executive action and in collaboration with Congress, to reinvest in outreach and enrollment, improve the affordability of ACA tax credits, and otherwise strengthen the ACA. In our view, the Improving Health Insurance Markets Proposed Rule will both improve and safeguard the accessibility, affordability, and quality of care for the patients and consumers we represent. We believe the proposed rule would reestablish a regulatory framework consistent with the plain language of the ACA and the purposes for which it was enacted, an undertaking we strongly support.

We respectfully offer the following comments and recommendations addressing specific provisions of the proposed rule.

Guaranteed Availability of Coverage, Past-Due Premiums

The statutory requirement that a participating issuer must make coverage available to all individuals who apply for it is a bedrock protection for the patients and consumers we represent, and for all Americans with preexisting conditions. In 2017, the prior administration announced it would permit issuers to deny coverage to people who the issuer says owe it, or a related entity, premiums. This policy is flatly inconsistent with the statute. It was adopted in response to concerns that were asserted but not supported by any evidence, and in spite of the clear barrier to coverage it imposes on individuals who for various reasons might find their enrollment rejected by an issuer. We are therefore pleased that HHS is reassessing this approach and we urge that it be reversed, and full guaranteed availability rights be restored, in the 2023 Payment Notice rulemaking.

Standardized Options for Marketplace Coverage

Standardized health plan designs offer numerous advantages to patients and consumers. Requiring plans to adhere to uniform cost-sharing parameters promotes informed decision-making: the shared standards reduce consumer confusion and make it easier to draw meaningful comparisons based on variables such as plans' premiums and network composition and design. Standardized plans can be a tool for improving coverage affordability: standard designs can, and should, exempt certain services, such as primary and mental health care, from the deductible, to provide consumers greater first-dollar value for their coverage. Standard plans should also contribute to larger policy efforts to reduce health disparities. For example, plan standardization can be used to lower cost barriers to services and supplies

¹ Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/a80ca017-c045-4415-87d9-97a952ff399c/020121-healthcare-principles43logos.pdf>.

that address health conditions that disproportionately affect people of color and others who historically have been underserved.

For these reasons, we support the return of standardized options on HealthCare.gov in 2023 and urge HHS to follow the lead of all of the states with standardized plan programs and require participating issuers to offer plans with standardized features.² We also suggest HHS consider adopting complementary QHP offering rules that would work in concert with standardized plan policy to enhance the consumer shopping experience and improve plan value. For example, most states that use standardized plans limit the number of non-standard designs issuers can offer, and HHS might do the same. At a minimum, HHS should reestablish and strengthen standards requiring an issuer's marketplace plans to be meaningfully different from each other. On the operational side, we request HHS weigh carefully how standardized plans can best be displayed on HealthCare.gov, with the goal of helping consumers easily identify these options. We believe the use of unique branding, such as that adopted by HHS during 2017-2018, is likely a helpful start and suggest additional consumer testing might be undertaken to identify best practices.

Navigator Program Standards

Resources that help consumers understand and select health care coverage are an essential component of any health care system. Recent survey work by the Kaiser Family Foundation found that 94 percent of consumers who received individual market enrollment assistance reported it was helpful; approximately 40 percent said it was unlikely they would have gotten coverage without it.³ As HHS recognizes, Navigators are trusted partners in their communities and, because of that, are uniquely positioned to help those they serve. By providing free, unbiased assistance to people who need health coverage, educating individuals about health insurance and their coverage options (including Medicaid), and facilitating enrollment through the marketplace, Navigators promote take-up of comprehensive coverage and contribute to producing a healthier, balanced risk pool. For these reasons, our organizations strongly opposed the systematic disinvestment from the Navigator program that occurred in recent years.

Our organizations are heartened to see the Biden administration begin to reinvest in Navigators and the consumers they serve. We appreciate the substantial increase in federal financial support made available by the administration to Navigators, boosting grant funding far above recent lows, and believe consumers would benefit significantly from further increases in program funding in future years.

We appreciate, too, the recommitment to the Navigator program reflected in the proposed rule. We strongly support the proposals to again require Navigators to assist consumers with various post-enrollment topics and to help consumers understand basic concepts and rights related to health coverage and how to use it. We agree that reinstating and strengthening these requirements will help ensure Navigators are trusted partners who are well prepared to assist patients and consumers and, in particular, vulnerable populations and members of historically underserved communities. As a part of this process, we urge the Department to review whether its current policies allow Navigators,

² Giovannelli, J., Schwab, R., & Lucia, K. (2021, July). *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Plan Value and Reduce Disparities*. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>.

³ <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>

particularly those situated within or associated with certain care facilities, to refer patients to collections agencies in the event they are not eligible for coverage.

As HHS works to restore and strengthen the Navigator program, we recommend that it also restore other community- and consumer-focused program requirements that were eliminated when funding was scarce. In particular, we suggest that marketplaces again be required to have at least two Navigator entities, at least one of which must be community-based and consumer-focused, and have a physical presence in the marketplace's service area. We also strongly encourage HHS to reassess its Navigator training curriculum, which was pared back significantly in recent years, to ensure Navigators receive training on the full range of topics necessary to perform their work and support patients and consumers from diverse backgrounds.

Exchange Direct Enrollment Option

In our comments to the Notice of Benefit and Payment Parameters for 2022 Proposed Rule (the "2022 NBPP"),⁴ we urged HHS not to finalize a policy under which states could, in effect, eliminate their marketplaces and outsource various statutory responsibilities to private entities. As we explained more fully in those comments, which are appended to this document, the so-called "Exchange Direct Enrollment Option" conflicts with federal law; invites unnecessary complexity and generates excessive burdens for consumers, including existing enrollees, that would likely reduce enrollment; and increases the risk that consumers would be steered to insurance products that do not provide ACA protections or qualify for premium tax credits. Since we wrote those comments, the rationale for this option, which was fundamentally deficient to begin with, has been further undermined by intervening changes in federal law — namely, enactment of the American Rescue Plan (ARP) Act. For these reasons, we strongly support the proposal to repeal the Exchange Direct Enrollment Option.

In addition, our organizations respectfully recommend that HHS strengthen standards for and oversight of Enhanced Direct Enrollment and Direct Enrollment (DE) entities. We remain concerned that the federal DE framework poses risks for consumers, who may be steered away from marketplace coverage and into non-compliant insurance products, and suggest additional consumer safeguards be considered in future rulemaking. HHS should also consider assessments or other fee structures for DEs as they rely on core datasets and backend access to the marketplaces through healthcare.gov. These dollars could be re-invested in healthcare.gov to ensure the system is meeting the demands of user and support maintenance and improvements over time.

Open Enrollment Period Extension

We are pleased that the proposed rule recognizes the value to consumers of extending the annual open enrollment period beyond its current, truncated length. We urge HHS to restore the open enrollment period to a full 90 days, which was the minimum length the period ran from 2014-2017. A full 90-day period would give consumers — including those who were automatically re-enrolled into unexpectedly more expensive plans, un-enrolled healthy individuals, and members of underserved communities who may face additional barriers to coverage — a better chance, during a busy time of year, to learn about their options and select a plan suited to their needs. The additional time will also increase the likelihood that Navigators and other assisters will be able to fully assist all the consumers who seek their help. Given that issuers are already required to effectuate coverage on the first day of the month following plan selection in other contexts, such as for the special enrollment period for individuals who lose

⁴ Health Partner Comments on 2022 NBPP. Available at: <https://www.lung.org/getmedia/5b1c9531-f2ad-49b0-8a4a-60eb6f0a9c96/health-partner-comments-on-nbpp-for-2022.pdf>.

minimum essential coverage, consumers could again be provided a full 90-day window without the need to delay coverage start dates until March.

In addition, while we support an open enrollment period extension that applies to all marketplaces, we urge HHS to clarify that such an extension would constitute a minimum standard and would not displace decisions by state-based marketplaces (SBMs) to offer more generous enrollment periods. Nearly all SBMs currently provide a longer open enrollment period than the federal 45-day default; six extend the sign-up period beyond January 15.⁵ SBMs should retain the flexibility to establish longer enrollment opportunities than the federal default if they determine that doing so is in the best interest of their consumers.

Finally, we encourage HHS to study whether a shift in the exact dates of the annual federal enrollment window—to begin, for example, on October 15 to align with the start of Medicare open enrollment—might facilitate outreach, reduce burdens on consumers, minimize consumer confusion, and contribute to higher enrollment. We also encourage HHS to ensure that all website and other technological updates and upgrades are in place prior to open enrollment so that the website does not need to be taken down, especially during prime scheduling times.

Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income No Greater than 150 Percent of the Federal Poverty Level

We appreciate the administration’s recognition of the barriers and burdens that continue to limit enrollment in comprehensive coverage through the marketplaces and share its assessment that multiple outreach and enrollment strategies must be undertaken to reduce these obstacles. To these ends, we strongly support the proposal to establish a special enrollment period (SEP) for qualified individuals at low incomes who are eligible for advance payments of the premium tax credit (APTC). Our organizations urge the administration to finalize this SEP as proposed for 2022, and to work with SBMs as necessary to ensure this option can be implemented effectively in all marketplaces that choose to pursue it.

Approximately 11 million people are eligible for subsidized marketplace coverage but are uninsured.⁶ An estimated 1.3 million of these individuals have incomes below 150 percent of the federal poverty level (FPL), meaning they are eligible for a \$0 premium silver plan and generous cost-sharing subsidies.⁷ As the proposed rule observes, many uninsured individuals have not enrolled in marketplace coverage because they are unaware of their options and/or believe they cannot afford to buy a plan. Indeed, evidence suggests less than half of uninsured individuals are aware of marketplace open enrollment.⁸ Of those who considered marketplace coverage but did not enroll, most say it was because the health plans were too expensive.⁹

⁵ The annual enrollment period for 2021 coverage extended beyond January 15, 2021, in six SBMs: California, Washington, D.C., Massachusetts, New Jersey, New York, and Rhode Island.

⁶ <https://www.kff.org/private-insurance/issue-brief/a-closer-look-at-the-uninsured-marketplace-eligible-population-following-the-american-rescue-plan-act/>

⁷ <https://www.kff.org/private-insurance/issue-brief/a-closer-look-at-the-uninsured-marketplace-eligible-population-following-the-american-rescue-plan-act/>

⁸ <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>

⁹ <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>

We believe the proposed monthly SEP, coupled with robust outreach and engagement, will help address these challenges and would provide a significant benefit to low-income, subsidy-eligible consumers who will be able to more easily access comprehensive coverage at low cost. This new opportunity is likely to be especially important to reduce coverage gaps for people who lose eligibility for Medicaid coverage, including for those who lose Medicaid following the end of COVID-19 public health emergency (PHE).

In addition, we strongly support the proposed method of operationalizing this SEP on HealthCare.gov. Despite generally low use of SEPs by those eligible, the burdens placed on consumers who hope to access coverage under an SEP have increased in recent years.¹⁰ We believe this approach has been counterproductive for the marketplaces and the consumers who rely on them by inappropriately deterring enrollment, both in general and with respect to younger and healthier enrollees in particular. It stands to reason that the individuals who overcome growing barriers to enrollment need coverage more (i.e., are less healthy) than those who are deterred by the process. And evidence indicates increased SEP documentation requirements have disproportionately reduced enrollment among young adults.¹¹ Therefore, in the context of a proposed SEP that is designed to facilitate coverage take-up by qualified individuals who are not likely familiar with or even aware of the range of enrollment rules and deadlines, an implementation approach that seeks to minimize enrollment barriers is especially appropriate. We believe the proposed process, under which the marketplace will grant an SEP based on a consumer's attestation and, post-enrollment, will verify the individual's projected income to determine the appropriate level of APTC, facilitates enrollment consistent with the statute while safeguarding program integrity. It should be finalized as proposed.

By promoting increased enrollment, the proposed SEP may enlarge and strengthen the individual market risk pool. We are skeptical of significant adverse selection in this situation, the risk of which is far outweighed by the benefits of higher coverage take-up. We note that several states currently offer year-round enrollment for low-income individuals via stable and established programs. In Massachusetts, Health Connector enrollment is generally available year-round for people with incomes up to 300 percent FPL, while New York and Minnesota operate Basic Health Programs through which eligible individuals up to 200 percent FPL can enroll anytime. This year, in response to COVID-19, HHS and every SBM authorized a broadly accessible SEP for the uninsured; in nearly every state, mid-year enrollment will be available for at least six months. And these enrollment flexibilities follow similar decisions by almost every SBM to offer multi-month COVID-19 SEPs in 2020. These commendable actions have provided a critical lifeline to coverage for literally millions of people. Adverse selection has not been an issue.

We support the proposal to make this SEP available indefinitely. At the same time, we recognize that, because of the ARP, low-income individuals have significantly greater access to \$0 or very low premium marketplace plans, and this significantly increases the potential effectiveness of the proposed SEP. We encourage congressional action to make the ARP's affordability improvements permanent and believe a

¹⁰ See Buettgens M, Dorn S, Recht H. More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods. The Urban Institute. <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>. Published November 2015.

¹¹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Pre-Enrollment Verification for Special Enrollment Periods. <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf>.

permanent SEP for qualified individuals with low-incomes would serve as a strong complementary policy.

Finally, we note that the availability of enhanced premium assistance for comprehensive marketplace coverage and, should this proposal be finalized, of a lower-burden path to enrollment in such coverage, provides an even stronger case for the Administration to take action on short-term, limited duration products. The Administration should begin rulemaking to reverse the 2018 rule extending the duration of these products and take additional steps to strengthen consumer protections as soon as possible.

User Fee Rates for the 2022 Benefit Year

Our organizations opposed the proposal in the 2022 NBPP to reduce substantially the user fee for issuers that participate on the federally facilitated marketplace (FFM) or a state-based marketplace on the federal platform (SBM-FP). We observed that the planned reduction likely would undermine the execution of core marketplace functions even as the country continues to weather the COVID-19 pandemic.

We appreciate that HHS has reanalyzed the likely impacts of the user fee reduction on the marketplaces and the individuals and families who rely on them. Further, we are pleased that, as a result of this analysis, HHS has determined to increase the 2022 fee rate to a level more in line with the benefits insurers derive from the program and the costs of sustaining it.

As HHS recognizes, expanded outreach and education provide significant value to consumers. We also believe these responsibilities are fundamental to supporting the work and purpose of the marketplaces and require greater investment. Similarly, the HealthCare.gov interface, which has improved over time, should receive additional and ongoing updates and improvements, which would benefit consumers and facilitate enrollment for health plans. For example, we suggest that HHS work to improve transparency and availability of information conveying marketplace plan features, so consumers can better understand their enrollment options. Our organizations also encourage HHS to implement strategies that will also help patients understand and purchase coverage based on premiums and other out-of-pocket costs such as deductibles, coinsurance, and co-pays. To reflect and support these essential activities, we believe the user fee rate should be set higher than proposed. At a minimum, HHS should maintain the 2022 user fee at 2021 levels, and should consider whether a year-on-year increase would be in the best interest of consumers.

Network Adequacy

Federal law requires that marketplace health plans maintain an adequate network of providers and, beginning in 2022, will obligate these plans (and others) to maintain accurate and up-to-date online provider directories. These protections are designed to ensure that marketplace enrollees have timely, meaningful access to the care and services they need, as well as accurate information sufficient to enable them to understand plans' networks and identify the plans and providers most likely to meet their needs. They are vital to the patients and consumers we represent.

We were deeply disappointed by the prior administration's decision to eliminate federal network adequacy standards for plans offered through the FFM and to abandon federal oversight of marketplace plan networks. It is critical to restore and strengthen these protections; we are pleased HHS intends to do so for the 2023 plan year and we look forward to commenting more fully on those forthcoming proposals.

As you revisit these issues, we urge increased scrutiny of networks' ability to provide culturally- and linguistically-competent care, as well as accessible provider offices and services. This means, among other things, a rigorous assessment of whether a network includes sufficient providers with appropriate language proficiencies, and/or provides sufficient access to appropriate language services, to ensure individuals with disabilities or limited English proficiency can obtain timely care. It also means networks must ensure access to culturally appropriate care that reflects the diversity of enrollees' backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, people with disabilities, and LGBTQ individuals. Further, to enable consumers to identify the plans and providers likely to meet their needs, all health plans must be required to indicate in their provider directories the languages, other than English, which are spoken by a provider and/or their staff and the accessibility features of the office.

Furthermore, we suggest HHS consider what additional data and materials plans must submit to facilitate a meaningful assessment of the adequacy of their networks. For example, plans should be required to report data showing out-of-network claims submitted (as opposed merely to such claims denied, as is currently required) and the types of providers and services involved. This information can help illuminate areas in which a network may not be well serving its enrollees.

Section 1332 Waivers, Statutory Guardrails

Our organizations previously objected to the guidance issued by the prior administration (the "2018 guidance") that purported to reinterpret the statutory guardrails governing the Section 1332 waiver program. As we explained at greater length in our prior comments, which we append here, the 2018 guidance plainly conflicts with federal law. It impermissibly encourages states to pursue waiver programs that circumvent non-waivable statutory protections and that would undermine coverage for people with preexisting conditions, including the patients we represent. The decision in the 2022 NBPP to codify these policies suffers the same flaws and compounds them.

For these reasons, we are gratified that the Departments have reevaluated this approach and strongly support the proposal to rescind the guardrail interpretations announced in the 2018 guidance and codified by the 2022 NBPP. We also strongly support the policies and interpretations described in the preamble to the Improving Health Insurance Markets Proposed Rule. The Departments' recommitment to ensuring that waivers must not adversely affect vulnerable and underserved residents is particularly appreciated and, we believe, well reflects congressional intent behind the program.

Section 1332 Waivers, Modification of Normal Public Notice Requirements

In November 2020, the Departments weakened public notice requirements for Section 1332 waivers during the COVID-19 PHE because existing requirements to obtain public input on waiver proposals "may impose barriers for states pursuing a proposed waiver request during the PHE." We opposed this decision, which, among other things, permits a state to delay its public notice and comment period until after it has already submitted its application to the Departments; delay the federal comment period; and reduce the length of these comment windows. We now oppose the proposal to extend this flexibility beyond the COVID-19 PHE to other "emergent" situations, broadly defined.

We appreciate that the Departments seek to provide flexibility to states to respond to urgent events that may threaten consumers' welfare. We believe, however, that the November 2020 revisions and these new proposals are at odds with statutory requirements and risk unintended negative consequences for the consumers we represent. By law, Section 1332 waiver applications must receive the benefit of public notice and comment at the state and federal levels, and these processes must be

sufficient to “ensure a meaningful level of public input.” Our organizations rely on these public comment periods to provide feedback on how waiver proposals will impact our patients and other key stakeholders. In our view, a rule that allows states to cut short the notice and comment periods, and to delay these essential processes until after governmental decisions on the waiver have already been made, does not allow for a meaningful level of public input. We urge the Departments not to finalize these proposals.

Conclusion

Thank you for the opportunity to provide these comments. If you have any questions, please contact Hannah Green (hannah.green@lung.org) with the American Lung Association.

Sincerely,

American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Lung Association
American Liver Foundation
American Kidney Fund
Alpha-1 Foundation
ALS Association
Arthritis Foundation
Asthma and Allergy Foundation of America
CancerCare
Cancer Support Community
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
National Alliance on Mental Illness
National Eczema Association
National Health Council
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
United Way Worldwide