



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

Attachments



December 28, 2020

The Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9914-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 (RIN 0938-AU18)

Dear Secretary Azar and Administrator Verma:

The undersigned organizations represent millions of patients facing serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the Department of Health and Human Services (HHS) to make the best use of the knowledge and experience our patients and organizations offer in response to this 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.

Our organizations recognize and appreciate provisions of the proposed rule that would expand patients' access to ACA coverage through new special enrollment periods (SEPs) and extension of the temporary premium tax credits. However, we are concerned that many of the other policies included in the 2022 Notice of Proposed Benefit and Payment Parameters (NBPP) would negatively impact patients' access to comprehensive coverage provided through the Affordable Care Act (ACA) Exchanges and shift additional health care costs and administrative burden to qualified health plan (QHP) enrollees.

Specifically, we oppose proposals to weaken the Section 1332 waiver application guardrails and to allow states to sideline ACA Exchanges and replace them with a fragmented system of direct enrollment (DE) and enhanced direct enrollment (EDE) entities. Our organizations are also concerned that proposals to weaken standards for DE and EDE entities could lead to consumer confusion and increase undesired enrollment in non-ACA-compliant plans that do not sufficiently cover patients' health care needs. Additionally, we oppose provisions of the proposed rule that would subject QHP enrollees to further scrutiny during SEPs, increase patients' out-of-pocket (OOP) obligations, weaken coverage provided through essential health benefit (EHB) benchmark plans, and reduce issuer fees. For these reasons, we urge CMS to exclude these provisions from the final rule.

Codification of Prior 1332 Guidance

Our organizations previously objected to the 2018 guidance² that violated the statutory guardrails for waiver applications under Section 1332 of the ACA³ and we strongly object to the current proposal to codify these guidelines in regulation. The 2018 guidance significantly undermines protections that ensure the quality and affordability of coverage for patients with pre-existing conditions. Codifying this guidance in regulation could cause lasting harm to vulnerable populations.

The 2018 guidance clearly conflicts with the statutory language that both authorizes these waivers and protects patients with pre-existing conditions. Section 1332 of the ACA outlines four clear guardrails that any waiver application must meet to be approved: coverage must be as affordable as it would be without the waiver; coverage must be as comprehensive as it would be without the waiver; a comparable number of people must be covered under the waiver as would be without it; and the waiver must not add to the federal deficit.⁴

The 2018 guidance directs federal officials to consider the number of people who would have *access* to affordable, comprehensive coverage under the 1332 waiver program, rather than the number of people

¹ Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/aafde78d-da8f-4067-ad6a-6b3429fac1b9/100720-healthcare-principles43logos.pdf>.

² State Relief and Empowerment Waivers, 83 Fed. Reg. 53575-53584 (Oct. 24, 2018). <https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf>.

³ Coalition Partners Letter to HHS Re: 1332 Guidance (December 18, 2018) <https://www.cff.org/About-Us/Our-Approach-to-Federal-State-and-Local-Policy/Our-Policy-Priorities/Briefings-Testimonies-and-Regulatory-Comments/Coalition-Letter-to-HHS-CMS-Treasury-Opposing-1332-Waiver-Guidance.pdf>

⁴ 42 U.S.C. § 18052 - Waiver for State innovation (2010). <https://www.law.cornell.edu/uscode/text/42/18052>.

who *enroll* in this coverage. This change enables states to design and promote initiatives that would erode the quality and affordability of insurance coverage, so long as consumers could theoretically access at least one plan that aligns with ACA affordability and quality standards.

The guidance also directs HHS and the Treasury to adopt a broader regulatory definition of insurance coverage than is allowed under the ACA. Per this definition, states may steer people into substandard coverage, including short-term, limited-duration insurance (STLDI) plans and association health plans, and may use private Exchanges to offer subsidies for non-ACA compliant plans. Such plans often do not cover the full range of benefits and services that patients rely upon to manage their conditions and are legally allowed to discriminate against consumers based on their health status. A study commissioned by the Leukemia and Lymphoma Society showed that individuals who enrolled in these plans and were later diagnosed with one of five conditions could face in excess of \$100,000 in uncovered medical bills.⁵

The 2018 guidance also permits states to use 1332 waivers to design EHB benchmark plans that provide less generous coverage for individuals. Although the standards for these plans would plainly be less comprehensive than outlined in the statute, they would still be able to satisfy the coverage guardrail regarding comprehensiveness as defined by the guidance. EHBs that patients rely upon to manage their conditions include preventive services, medications, visits with primary and specialty care providers, emergency services, and others. Allowing states to establish less robust coverage requirements could seriously harm patients' access to care and patients' health outcomes.

Finally, the 2018 guidance removes key language from previous guidance prohibiting states from using the waiver program in a manner that would harm certain vulnerable populations, including older Americans, individuals with low incomes, and those with or at risk of developing serious health issues. It omits earlier guidance that requires 1332 waivers to maintain coverage with an actuarial value equal to or greater than 60 percent as well as include a maximum out-of-pocket spending limit compliant with the ACA. At the same time, the guidance allows for policies that could fundamentally alter the risk pool for a state's individual marketplace, making comprehensive coverage unaffordable for some and jeopardizing marketplace stability. The resulting lack of access to care could have devastating short- and long-term consequences for many of the millions of patients we represent. In effect, this omission invites waiver applications that would leave patients responsible for excessive cost-sharing and could jeopardize their health and financial wellbeing.

The new rule proposes codifying the 2018 guidance, encouraging HHS and the Treasury to rely upon the flawed 2018 guidance when evaluating state 1332 waiver applications and the implementation and outcomes of policies authorized by such waivers. Our organizations oppose this codification and urge the Administration to withdraw provisions related to the 2018 guidance on 1332 waivers from the final rule.

Elimination of the Exchanges

In November 2020, CMS approved Georgia's 1332 waiver application, enabling the state to eliminate HealthCare.gov – the single, centralized web platform used to facilitate enrollment in ACA marketplace plans, Medicaid, and CHIP – and replace it with a fragmented network of private-sector insurers, web-brokers, agents, and brokers.⁶ The 2022 NBPP proposes creating an expedited pathway so that other states

⁵ The Impact of Short-Term, Limited-Duration Policy Expansion on Patients and the ACA Individual Market. Milliman Actuarial. <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf> Published February 2020.

⁶ Department of Health and Human Services, Centers for Medicare and Medicaid Services. Letter to Governor Brian Kemp from CMS Administrator Seema Verma Communicating Approval of Georgia's State Innovation Waiver, November 1, 2020.

may transition to such a system without submitting a waiver. Our organizations strongly oppose this proposal, given the added complexity it would create for consumers and the potential for brokers to steer consumers to non-qualified health plans and not inform consumers of their eligibility for Medicaid, CHIP, or advance premium tax credits (APTCs). In addition, allowing states to violate federal statute by abandoning a centralized website without a waiver clearly violates the statutory requirements of the ACA.

The ACA requires all states to create or adopt a health insurance marketplace,⁷ either through a state-based Exchange (SBE), a federally-facilitated exchange (FFE), or through a state-based marketplace that uses the federal platform (SBM-FP). These Exchanges were intended to simplify enrollment in non-large group health coverage by serving as a single place where consumers could compare plans and apply for financial assistance. The Exchanges also provide a guarantee of high-quality insurance coverage; all qualified health plans (QHPs) offered through Exchanges must adhere to specified actuarial standards and provide certain consumer protections.

As noted in our previous comments⁸ to the Department, we are concerned that transitioning to an insurer- and broker-facilitated enrollment system would reduce enrollment in plans with comprehensive coverage and would jeopardize quality and affordable healthcare coverage for patients. While insurance agents and brokers can play a role in helping individuals understand and enroll in health care coverage,⁹ they may be subject to potential conflicts of interest as a result of the way that they are compensated.¹⁰ Under the proposed guidelines, these entities may market non-ACA-compliant plans alongside QHPs, which may result in consumers purchasing lower-premium plans that in fact offer minimal coverage.

The current Exchanges serve as a one-stop-shop for determining eligibility for commercial plans, APTCs, Medicaid, and CHIP. Under a DE-facilitated system, individuals who are not sure whether they qualify for Medicaid or for APTCs would need to apply for coverage under two separate systems. Not only is this process redundant; it also creates the potential for insurance brokers to steer Medicaid- or CHIP-eligible individuals away from these low-cost, high-quality coverage options. In addition, insurance brokers and agents are not required to notify consumers about their potential Medicaid or CHIP eligibility.

We are also concerned about the incentives put in place to motivate DEs to enroll individuals in non-compliant plans in order to earn a commission. Brokers frequently receive bonuses from insurers for signing consumers up for certain plans, creating an incentive for brokers to enroll individuals in plans that may not be the best option for them. Some insurers incentivize the sale of STLDI plans, which are generally less expensive for insurers because they do not provide comprehensive coverage. Broker commissions for STLDI plans can reach 20 percent of plan costs or higher, while ACA plan commissions are often a far lower, flat

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf.

⁷ 42 U.S.C. § 18031 (2010). <https://www.law.cornell.edu/uscode/text/42/18031>.

⁸ Coalition Comments on the State of Georgia's 1332 Waiver Application. September 18, 2020. <https://rarediseases.org/wp-content/uploads/2020/09/Health-Partner-Access-2.0-Comments-FINAL.pdf>

⁹ Giovanelli J, Curran E. Factors Affecting Health Insurance Enrollment Through the State Marketplaces: Observations on the ACA's Third Open Enrollment Period. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2016/jul/factors-affecting-health-insurance-enrollment-through-state>. Published July 22, 2016.

¹⁰ Corlette S, Blumberg LJ, Wengle E. Insurance Brokers and the ACA: Early Barriers and Options for Expanding Their Role. The Urban Institute. <https://www.urban.org/sites/default/files/publication/39571/2000091-Insurance-Brokers-and-the-ACA.pdf>. Published February 2015.

rate.¹¹ There is already evidence that this financial incentive has driven misleading marketing that has led individuals to unknowingly enroll in coverage that lacks key patient protections.^{12,13} Recently, the U.S. Government Accountability Office (GAO) conducted a study of brokers and insurance representatives in states where non-compliant plans are readily available to consumers. In almost 25 percent of cases, GAO representatives posing as consumers with significant health care needs were inappropriately directed to a form of non-QHP-compliant coverage that would not cover care related to their condition.¹⁴

Additionally, individuals already enrolled in health plans could unknowingly lose their coverage under the proposed rule. Today, HealthCare.gov and SBEs can automatically re-enroll individuals who signed up for coverage last year but who do not select a new plan for the following year. In 2020, approximately 3.3 million individuals—nearly a third of all ACA marketplace enrollees—were re-enrolled in health care coverage.¹⁵ Under a DE Marketplace, it is unclear which entities would be capable of or responsible for determining eligibility for re-enrollment. The loss of access to these features would unnecessarily burden consumers and would likely result in enrollment losses.

Our organizations question the stated rationale for permitting states to transition to a DE-facilitated system. The proposed rule states that “it is inherently difficult for Exchanges to keep up with the rapid pace of innovation in e-commerce and the ever-evolving preferences of online shoppers,” necessitating a private sector approach to facilitating plan selection. However, an evaluation of 2019 SBE enrollment efforts noted that several SBEs have launched innovative online tools to assist with eligibility determinations and plan selection.¹⁶ SBEs are also able to collect real-time data on consumers’ online experience and tailor their websites accordingly.¹⁷ While CMS notes that SBEs may experience “choke points” and other issues with functionality, it does not provide a compelling rationale for why these issues could not be resolved with additional investment in server upgrades and website maintenance.

States cannot enact policies that clearly conflict with federal law without completing the waiver process. The proposed rule claims that “the applicable statutory provisions do not require either the federal government or states to operate an enrollment website” and that “an Exchange can continue to meet...the minimum functions outlined in the statute without operating a singular consumer-facing enrollment website.” This directly contradicts federal statute, which clearly outlines that each state must “**maintain an**

¹¹ Appleby J. Short-Term Health Plans Boost Profits For Brokers And Insurers. *Kaiser Health News*.

<https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>. Published December 21, 2018.

¹² Straw T. “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>. Published March 15, 2019.

¹³ Gantz S. A Philly woman’s broken back and \$36,000 bill show how some health insurance brokers trick consumers into skimpy plans. *The Philadelphia Inquirer*. <https://www.inquirer.com/health/consumer/limited-benefit-skimpy-health-plans-sales-pitch-20191114.html>. Updated November 14, 2019.

¹⁴ U.S. Government Accountability Office. Private Health Coverage: Results of Covert Testing for Selected Offerings [Letter to Senators Robert P. Casey, Jr. and Debbie Stabenow]. <https://www.gao.gov/assets/710/708967.pdf>. Published August 24, 2020.

¹⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Health Insurance Exchanges 2020 Open Enrollment Report. <https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf>. Published April 2020.

¹⁶ Schwab R, Corlette S. ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2019/aca-marketplace-open-enrollment-numbers-reveal-impact>. Published April 16, 2019.

¹⁷ Schwab R, Corlette S. ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2019/aca-marketplace-open-enrollment-numbers-reveal-impact>. Published April 16, 2019.

Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans.”¹⁸ CMS seems to assert that Congress did not explicitly specify that the web portal must be consumer-facing, which flies in the face of the language just quoted; the statute requires that individuals be able to obtain plan information themselves from the Exchange. Further, CMS seems to claim that the statutory requirement for states to *facilitate* enrollment in QHPs does not amount to a requirement for individuals to be able to *enroll* in coverage through the Exchanges. This contradicts the consumer choice mandate of the statute: “Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.”¹⁹ Accordingly, CMS’s reasoning is not only strained but in direct conflict with the requirements of the statute.

Should these provisions be finalized, we anticipate that they would result in a serious impact on the health of patients who are in treatment and rely on regular visits with health care providers or daily medications to manage or treat their condition. Patients, including those with pre-existing conditions, cannot afford unexpected gaps in care. We therefore urge CMS to reject a model that would complicate the enrollment process and potentially delay care and treatment.

Standards for Enhanced Direct Enrollment (EDE) and Direct Enrollment (DE) Entities

Our organizations strongly oppose proposals in the 2022 NBPP that would, if implemented, further expand DE and EDE pathways and provisions that would weaken operating standards for these pathways. As noted above, DE entities are able to offer non-ACA-compliant health plans alongside QHPs, are not required to advise or assist individuals with Medicaid or CHIP enrollment, and may benefit financially from enrolling consumers in coverage that does not best suit their individual needs. EDE entities further sideline the role of Exchanges such that individual consumers never interact with HealthCare.gov or an SBE and may therefore never see the full range of coverage options for which they are eligible.

The current one-stop-shop Exchange model enables patients with chronic and acute health conditions to compare plan prices and benefit designs. Exchanges are required to list all QHPs for which an individual is eligible and can also screen applicants for Medicaid and CHIP eligibility. ACA assisters and navigators work solely on behalf of the consumer and are prohibited from receiving direct or indirect compensation from health insurers.²⁰

The DE pathway potentially offers far less consumer protection. Through the DE pathway, insurance companies and brokers may use their own websites to assist individuals through the entire process of applying for health insurance and accessing premium tax credits. With the exception of web-brokers, DEs and EDEs are not required by federal law to display all available QHPs or to facilitate enrollment into all QHPs. These entities could inappropriately obscure plan information for their own financial gain; for example, insurance agents may choose not to discuss plans not sold by their company, and brokers may choose not to discuss plans for which they do not receive a commission. Under this model, patients may lose the ability to choose the right plan for them. Enrollment in the wrong insurance plan could cause serious harm, especially for patients with significant health needs like those we represent.

¹⁸ 42 U.S.C. §18031(d)(4)(C) (2010). <https://www.law.cornell.edu/uscode/text/42/18031> [emphasis added].

¹⁹ 42 U.S.C. §18032(d)(3)(A) (2010). <https://www.law.cornell.edu/uscode/text/42/18032>.

²⁰ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. An Assister’s Guide to Working with Agents and Brokers. <https://marketplace.cms.gov/technical-assistance-resources/working-with-agents-and-brokers.pdf>. Published October 2015.

CMS proposes requiring DE entities that market both QHPs and non-ACA-compliant plans to display information about these different plan types on three separate webpages. While our organizations appreciate the intention to differentiate QHPs from non-ACA-compliant plans, we believe that this requirement would create unnecessary consumer confusion and may lead people to inappropriately enroll in substandard coverage. We are also concerned that CMS has created loopholes to this new policy which would enable some DEs to continue to market on-Exchange QHPs, off-Exchange QHPs, and non-compliant plans on the same webpage, which could expose consumers to products that do not meet their medical need in addition to furthering consumer confusion.

The proposed rule would also grant a 12-month grace period to certain EDE websites that are required to translate website content into a language spoken by a limited English proficient (LEP) population that makes up 10 percent or more of a state's total population. Although CMS states that this change is aimed at incentivizing EDEs to operate in markets with a high number of individuals with LEP, we question the extent to which these individuals would benefit from websites that are not translated into their language during the first year of the EDE's operation. We are also concerned that this policy could delay website translation that could otherwise be implemented in fewer than 12 months in order to engage in "cream skimming," as having LEP has been correlated with poorer health status.²¹ In order to decrease the already substantial barriers that people with LEP face when enrolling in coverage, we urge the Administration to exclude the 12-month grace period for EDEs from the final rule. All entities that assist with QHP enrollment should be fully compliant with language accessibility requirements from day one.

Web-Brokers Should Not Be Permitted to Obscure Plan Details

Given the concerns outlined in prior sections of this letter, our organizations strongly object to the proposed exceptions to the requirement for web-brokers to disclose and display all QHP information provided by the Exchange or directly by QHP insurers. Under the new rule, web-brokers would be able to obscure information about QHPs that are not sold through their websites. Specifically, web-brokers would be required to provide a summary of benefits and coverage and quality ratings for plans sold through the website but would not be required to display this information for other QHPs available through the Exchanges. We believe that this mismatch in information could enable web-brokers to direct consumers to plans that are profitable for the broker but may not be appropriate for the consumer's health needs. We urge CMS to reconsider this provision and maintain that all DEs must display all available information for all health plans available to the consumer.

Enhanced Special Enrollment Period (SEP) Verification

The proposed rule would require SBEs to conduct eligibility verification for at least 75 percent of new enrollments through SEPs for consumers who were not already enrolled in Exchange coverage. Our organizations oppose this change, as these documentation requirements can be burdensome for many consumers and inhibit legitimate enrollment.

In 2018, CMS began requiring consumers who purchased coverage through HealthCare.gov to provide pre-enrollment verification of their eligibility for a SEP. This change was administered in response to issuer complaints that enrollees were abusing the SEP process. However, there is scant evidence to suggest that this is the case. In fact, according to one national study, fewer than 15 percent of individuals who lose employer-sponsored insurance (ESI) enroll in a QHP through a SEP for which they qualify.²² This low level of

²¹ Sentell T, Braun KL. Low health literacy, limited English proficiency, and health status in Asians, Latinos, and other racial/ethnic groups in California. *J Health Commun.* 2012;17 Suppl 3(Suppl 3):82-99. <https://doi.org/10.1080/10810730.2012.712621>.

²² Buettgens M, Dorn S, Recht H. More than 10 Million Uninsured Could Obtain Marketplace

uptake could be due to adverse selection, lack of awareness of SEPs among individuals who qualify for them, issuer decisions to limit marketing and broker commissions outside of open enrollment periods (OEPs), and/or other barriers.²³ We encourage CMS to evaluate the reasons underlying SEP underuse and pursue opportunities to raise awareness and utilization of SEPs among those who qualify.

Issuers have also claimed that SEP enrollees retain coverage for less time than OEP enrollees. However, in the 2018 NBPP, HHS noted that QHP attrition rates were no different among people who enrolled through a SEP than among those who gained coverage during OEPs. HHS concluded that “any such gaming [of the SEP system], if it is occurring, does not appear to be occurring at sufficient scale to produce statistically measurable effects.”²⁴

Research suggests that requiring additional documentation during SEPs discourages enrollment in QHPs, particularly among younger, healthier adults. In June 2016, CMS introduced a Special Enrollment Confirmation Process under which consumers enrolling through HealthCare.Gov during the most common SEPs were directed to provide documentation to confirm their eligibility. In the four and a half months after the program was implemented, SEP enrollment fell by 20 percent compared with the previous year.²⁵ During this time period, young adults were disproportionately likely to fail to complete the verification process: 45 percent of applications with a household contact ages 18-24 failed to submit additional documentation to verify a qualifying event, compared to 27 percent of those with a household contact ages 55-64.²⁶ Our organizations encourage further study of the impact of pre-enrollment verification, particularly with respect to the impact of these policies on Marketplace risk pools.

Finally, we are deeply concerned that CMS is pursuing and implementing additional barriers to obtaining coverage during a pandemic, and at a time when many individuals have experienced changes in employment that would qualify them for a SEP. Previously, CMS has waived documentation requirements for SEPs and accepted self-attestation of changes in income, employment, or household makeup in order to expedite health insurance enrollment during natural disasters.²⁷ Our organizations urge CMS to forgo increasing administrative burdens upon people seeking insurance coverage during this disaster, and instead work to streamline the QHP eligibility and enrollment processes.

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.

²³ Hancock J. Licking wounds, insurers accelerate moves to limit health-law enrollment. *Kaiser Health News*.

<http://khn.org/news/licking-wounds-insurers-accelerate-moves-to-limit-health-law-enrollment/>. Published February 4, 2016.

²⁴ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program - 81 Fed. Reg. 94058 (2016).

<https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>.

²⁵ 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>.

²⁶ 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>.

²⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Emergency and Major Disaster Declarations by the Federal Emergency Management Agency (FEMA) – Special Enrollment Periods (SEPs), Termination of Coverage, and Payment Deadline Flexibilities, Effective August 9, 2018 [Letter to All Federally-facilitated Exchange (FFE) Qualified Health Plan (QHP) and Stand-alone Dental Plan Issuers].

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf>. Published August 9, 2018.

Changes to the Premium Adjustment Percentage Index (PAPI)

The 2022 NBPP proposes to increase the premium adjustment percentage, in accordance with the revised calculation methodology adopted in 2019.²⁸ We continue to oppose these changes and urge the Administration to revise their policy in this critical area. The proposed 2022 premium adjustment percentage reflects an increase of about 6.4 percent over the 2021 percentage. A higher premium adjustment means higher required contributions from consumers by decreasing premium tax credit amounts. Thus, this continued and accelerating growth under the new methodology shifts ever-greater costs onto families. Premiums for most subsidized marketplace consumers will increase 4.7 percent in 2022, according to analysis by the Center on Budget and Policy Priorities.²⁹ That increase amounts to a \$360 premium increase for a family of four earning an \$80,000 income. The limit on total out-of-pocket expenses will be \$400 higher for individuals and \$800 higher for families than they would be absent the 2019 methodology change. Increased marketplace premium and out-of-pocket costs will disproportionately impact lower-income individuals and those with higher healthcare needs. Facing these enormous costs, some individuals may choose to forgo necessary care, leading to costly and dangerous complications.

Increases to the Maximum Annual Limitation on Cost-Sharing (MOOP)

The 2022 NBPP proposed rule would increase the cap on annual maximum out-of-pocket (MOOP) payments for QHPs by 6.4 percent. As a result of changes to the PAPI that were codified in the 2021 NBPP, this threshold is increasing more quickly than it has in prior years, resulting in greater cost-sharing obligations for enrollees. The proposed change to the premium measure will also result in a faster growth of the net premiums paid by consumers on the Marketplaces, and a faster growth in the MOOP limit paid by all Americans, including those with large group employer coverage. Our organizations are concerned that raising out-of-pocket costs will result in more Americans foregoing medically necessary services, leading to worse health outcomes and more uncompensated care costs, especially for those with pre-existing conditions.³⁰

Studies show that a growing number of Americans are underinsured and therefore experience difficulty paying the out-of-pocket costs associated with their care, including deductibles, copays, and coinsurance.³¹ This holds true for a cross-section of Americans, including those with large group employer coverage as well as those with individual coverage, and it is an especially pressing concern for people with chronic health conditions.³² For these reasons, we urge CMS to return to its previous method of calculating the PAPI in order to reduce the out-of-pocket burden on consumers.

Marketplace User Fee

For the federally facilitated marketplace, insurers face a reduced fee from 3.0 to 2.25 percent of total monthly premiums, and state-based marketplace insurers using the federal platform have a proposed fee

²⁸ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Notice of Benefit and Payment Parameters for 2022 Proposed Rule Fact Sheet. <https://www.cms.gov/files/document/proposed-2022-hhs-notice-benefit-and-payment-parameters-fact-sheet.pdf>. Accessed December 2020.

²⁹ Straw, T. Trump Proposal Threatens Coverage of HealthCare.gov Enrollees. *CBPP*. 2020, Dec 7. cbpp.org/blog/trump-proposal-threatens-coverage-of-healthcaregov-enrollees. Accessed Dec 12, 2020.

³⁰ Multiple studies for the Medicaid population bear this out. See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. *J Gen Intern Med*. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." Center on Budget and Policy Priorities (July 2005), available at <http://www.cbpp.org/5-31-05health2.htm>.

³¹ The Commonwealth Fund. "Health Insurance Coverage 8 Years After the ACA". February 7, 2019. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

³² Altman, Drew. "It's not just the uninsured – it's also the cost of health care". August 20, 2018. Available at: <https://www.axios.com/not-just-uninsured-cost-of-health-care-cdcb4c02-0864-4e64-b745-efbe5b4b7efc.html>.

reduction from 2.5 to 1.75 percent. States using the direct enrollment marketplace would see a user fee of 1.5 percent. All told, CMS estimates that the reduced user fee would result in savings to insurers of about \$270 million in 2022 and about \$400 million in 2023. Our organizations question the necessity of these fee reductions, given that insurers across most markets have seen their profit margins increase since the start of the pandemic.³³

CMS has partly justified the reduced user fee by claiming that the resulting loss in revenue would be offset through cost-savings achieved by transitioning to a DE marketplace. According to this rationale, the consumer support and protections provided through HealthCare.gov and SBEs would be cut at a time when these functions are more critical than ever. Robust outreach and enrollment efforts are critical to helping patients learn about their healthcare coverage options and enroll in plans that are appropriate for their healthcare needs, especially as patients navigate changes in jobs and insurance coverage as a result of the COVID-19 pandemic. We encourage CMS to instead increase user fees and use the resulting funds to improve and update HealthCare.gov.

Extension of the Temporary Premium Credits Through 2021

As a result of job and income losses due to COVID-19, many Americans are facing severe financial hardship which will likely continue over the following months. Our organizations support the Administration's proposal to extend the option for QHP issuers to offer temporary premium credits through the 2021 MLR reporting year and beyond.

The COVID-19 pandemic has resulted in debilitating illness and death on a massive scale. As of December 14, 2020, there were more than 16 million COVID-19 cases and 300,000 COVID-19-related deaths in the United States.³⁴ The average cost of a COVID-19 related hospitalization reaches \$20,000 for mild-to-moderate cases and \$80,000 for severe cases.³⁵ Many pre-existing chronic conditions, such as those experienced by the patients we represent, increase the risk of severe COVID-19 illness.³⁶ Moreover, many COVID-19 survivors are faced with lasting medical complications, including extreme fatigue, chronic pain, difficulty breathing, and impaired memory and concentration.³⁷ Meanwhile, millions of Americans are

³³ The Kaiser Family Foundation. "Health Insurer Financial Performance Amid the Coronavirus Pandemic". October 12, 2020. Available at: <https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-amid-the-coronavirus-pandemic/>.

³⁴ Coronavirus in the U.S.: Latest Map and Case Count. *New York Times*.

<https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>. Updated December 14, 2020. Accessed December 2020.

³⁵ Rae M, Claxton G, Kurani N, McDermott D, Cox C. Potential costs of COVID-19 treatment for people with employer coverage. Peterson-KFF Health System Tracker. <https://www.healthsystemtracker.org/brief/potential-costs-of-coronavirus-treatment-for-people-with-employer-coverage/>. Published March 13, 2020. Accessed December 2020.

³⁶ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. COVID-19 (Coronavirus Disease): People with Certain Medical Conditions. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>. Updated December 1, 2020. Accessed December 2020.

³⁷ Rubin R. As Their Numbers Grow, COVID-19 "Long Haulers" Stump Experts. *JAMA*. 2020;324(14):1381–1383. doi:10.1001/jama.2020.17709.

estimated to have lost ESI coverage as a result of COVID-19-related job loss,^{38,39,40} and many of these individuals likely remain uninsured despite qualifying for APTCs.⁴¹

Both the health and economic consequences of COVID-19 are expected to continue through 2021, as cases are trending upwards, and many localities are imposing business restrictions in order to control the spread of the virus. Permitting QHP issuers to provide temporary premium credits to help enrollees afford and maintain coverage during the public health emergency is an important step in helping Americans feel more secure in seeking health care for COVID-19 symptoms and in managing any chronic conditions during the pandemic.

Essential Health Benefit (EHB) Benchmark Flexibilities

Our organizations continue to oppose the EHB flexibilities established in the 2019 NBPP. We view defining the EHB package as among the most important regulatory tasks required by the ACA. All plans should be required to cover a full range of necessary health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. In contrast to these principles, the 2019 EHB benchmark flexibilities could allow issuers to weaken coverage. While all consumers could be negatively impacted by less-generous EHB benchmark plan design, such changes could be especially harmful to healthcare consumers with higher costs and needs, including individuals with pre-existing conditions. Our concerns are heightened by the fact that prohibitions on annual and lifetime limits only apply to EHB benefits, meaning that the total out-of-pocket costs for consumers could be even greater than these thresholds.

Untimely Notice of an SEP Triggering Event

The 2022 NBPP proposes new rules related to SEPs that would extend the window for enrollment through a SEP window for individuals who may not have received timely notice of a SEP triggering event. Under the proposed rule, such individuals would be able to enroll up to 60 days from the date that they knew, or reasonably could have known, of the triggering event. In 2015, large national insurers estimated that as many as 30 percent of their Marketplace members enrolled during a SEP.⁴² However, it is likely that many more people could enroll during a SEP given greater flexibility. Numerous reports document the barriers faced on both sides of the SEP notice process. Patients may lack awareness or understanding of SEPs or may struggle to gather and report proof of a qualifying life event within the 60-day window.⁴³ Enrollment

³⁸ Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured: Evidence from the Household Pulse Survey, April 23–July 21, 2020. The Urban Institute. <https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf>. Published September 2020. Accessed December 2020.

³⁹ Bivens J, Zipperer B. Health insurance and the COVID-19 shock. Economic Policy Institute. <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/>. Published August 26, 2020. Accessed December 2020.

⁴⁰ Fronstin P, Woodbury SA. How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic? The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic>. Published October 7, 2020. Accessed December 2020.

⁴¹ McDermott D, Cox C, Rudowitz R, Garfield R. How Has the Pandemic Affected Health Coverage in the U.S.? Kaiser Family Foundation. <https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/>. Published December 9, 2020. Accessed December 2020.

⁴² America's Health Insurance Plans. Appropriate use of special enrollment periods is key to exchange stability, affordability for consumers. 2016 Feb 10. <https://www.ahip.org/wp-content/uploads/2016/03/AHIP-BCBSA-SEP-Analysis-Feb16.pdf>. Accessed Dec 12, 2020.

⁴³ Mulligan, Jessica, Arriaga, Stephanie and Jeannette Torres. An ethnographic study of enrollment obstacles in Rhode Island, USA: struggling to get covered on an Affordable Care Act insurance marketplace. *Critical Public Health*. 2019, 29:5, 547-559, DOI: 10.1080/09581596.2018.1495827.

assistants report conflicts between SEP and open enrollment period messaging; difficulty developing clear explanation due to the diversity of SEP qualifying events; and challenges reaching consumers who qualify before the end of the 60-day enrollment window.⁴⁴ We support expanding SEPs to 60 days past the receipt of notice regarding SEP eligibility, which will likely help to increase enrollment and promote continuity of coverage.

Changing Plans as a Result of Changes in Advanced Premium Tax Credit (APTC) Eligibility

Our organizations support the Administration's proposal to promote continuity of coverage by enabling QHP enrollees who lose APTC eligibility to enroll in a QHP of a lower metal level. Currently, individuals who are no longer eligible for APTCs due to changes in income or household size may experience a substantial increase in their QHP premiums and may no longer be able to afford their monthly premium payments, resulting in a loss of insurance coverage. Enabling these individuals to enroll in a QHP with a lower premium would prevent them from experiencing sudden loss of insurance. We believe that this change is particularly important in light of the COVID-19 pandemic, during which many individuals have experienced sudden changes to their income.

In the proposed rule, CMS seeks comment on strategies to minimize consumer confusion resulting from this new policy and to educate consumers about the potential trade-offs of enrolling in lower metal level plans, which typically have lower premiums but higher cost-sharing obligations. It is our understanding that most individuals would find out that they are no longer eligible for APTCs only after reporting a change in income, residence, or household makeup to the ACA Marketplace; otherwise, they would be required to reconcile any APTC overpayment when filing taxes.

Our organizations encourage CMS to require Exchanges to immediately notify consumers within 15 days once it is determined that they are no longer eligible for APTCs through written notice on Exchange websites, via electronic communication (if elected by the consumer), and/or via mail. Notices should be written in plain language and emphasize the cost of the consumer's currently elected plan without APTCs, the ability for consumers to switch to a lower metal level plan, and the timeline for selecting a new plan. Notices should additionally contain language and/or visual examples of the trade-offs between plans' lower premiums and higher cost-sharing, with examples of plan selection scenarios and links to online tools or calculators that can help consumers compare plans based on their anticipated health care needs. Consumers should be provided with the website, phone number, email address, and any other helpful contact information through which they can select a new plan or ask questions about plan selection.

We also encourage CMS to regularly advise consumers that they must report substantial changes in household makeup or income to their local Exchange in order to adjust their APTC allocation; otherwise, they will be required to repay any excess APTC amounts through taxes.⁴⁵ Notices should provide examples of circumstances that can affect APTC eligibility, including lump sum payments of Social Security benefits; lump sum taxable distributions from an individual retirement account or other retirement arrangement; debt forgiveness or cancellation; marriage; divorce; birth or adoption of a child; etc. Consumers should be provided with the website, phone number, email address, and any other helpful contact information through which they can notify their state Exchange of changes in household makeup, income, or residence.

⁴⁴ Wishner, Jane B., Ahn, Sandy, Lucia, Kevin, and Sarah Gadsen. Special Enrollment Periods in 2014: A Study of Select States. *Urban Institute*. 2015 Feb. https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/UI_Special-Enrollment-Periods-2014.pdf. Accessed Dec 14, 2020.

⁴⁵ U.S. Department of the Treasury, Internal Revenue Service. Questions and Answers on the Premium Tax Credit. <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit>. Updated November 24, 2020. Accessed December 2020.

SEP Eligibility Following Cessation of Employer Contributions to COBRA

Our organizations support the creation of a SEP for individuals who transition off of COBRA coverage due to diminishing employer contributions. As a result of the COVID-19 pandemic, millions of Americans are estimated to have lost ESI.^{46,47,48} While job loss is currently considered to be a SEP qualifying event, those who elect to remain on their employer's insurance plan through COBRA may have limited coverage options when their former employer ceases premium contributions. Individuals who opt to enroll in COBRA coverage also tend to have higher medical expenses compared to other large group enrollees,⁴⁹ suggesting that these individuals have greater medical needs. Enabling individuals who lose COBRA coverage to enroll in Marketplace coverage could help ensure that these individuals can continue to access care.

Conclusion

Our organizations are concerned about the approach the Administration has taken to many policies included in the NBPP for 2022, including the codification of the 2018 Section 1332 guidance, allowing states to eliminate the ACA Marketplace, and the broad expansion of DE and EDE amongst others. We therefore urge the Department not to finalize these provisions.

Again, thank you for the opportunity to offer its comments on this proposed rule. Should you have any questions about our comments, please contact Katie Berge, Director of Federal Government Relations at The Leukemia & Lymphoma Society at katie.berge@lls.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
CancerCare
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America

⁴⁶ Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured: Evidence from the Household Pulse Survey, April 23–July 21, 2020. The Urban Institute. <https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf>. Published September 2020. Accessed December 2020.

⁴⁷ Bivens J, Zipperer B. Health insurance and the COVID-19 shock. Economic Policy Institute. <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/>. Published August 26, 2020. Accessed December 2020.

⁴⁸ Fronstin P, Woodbury SA. How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic? The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic>. Published October 7, 2020. Accessed December 2020.

⁴⁹ Petersen-KFF Health System Tracker. Total Health Spending: Per Person Spending. Average annualized spending for enrollees covered under COBRA and all other large group enrollees, 2018. <https://www.healthsystemtracker.org/indicator/spending/per-capita-spending/>. Accessed December 2020.

National Alliance on Mental Illness
National Health Council
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society



December 18, 2018

The Honorable Alex M. Azar II
 Secretary
 U.S. Department of Health and Human Services
 200 Independence Avenue, SE
 Washington, DC 20201

The Honorable Steven T. Mnuchin
 Secretary
 U.S. Department of the Treasury
 1500 Pennsylvania Avenue, NW
 Washington, D.C. 20220

Re: State Relief and Empowerment Waivers (CMS 9936-C)

Dear Secretary Azar and Secretary Mnuchin:

Thank you for the opportunity to submit comments on the new guidance for states applying for waivers under Section 1332 of the Affordable Care Act (ACA). The undersigned organizations urge the Department of Health and Human Services (HHS) and the Department of the Treasury (Treasury) to withdraw the guidance.

The 24 undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge HHS and Treasury to utilize the collective insight and experience our patients and organizations offer in response to the new guidance.

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 package.

Section 1332 waivers allow states to waive specified provisions of the ACA, provided the state's waiver plan meets four statutory guardrails: coverage must be as affordable as it would be without the waiver; coverage must be as comprehensive as it would be without the waiver; a comparable number of people must be covered under the waiver as would be without it; and the waiver must not add to the federal deficit. In 2015, HHS and Treasury issued guidance to states on how to design these waivers. The new State Relief and Empowerment Waivers guidance supersedes the 2015 guidance. Unfortunately, the new guidance neither adheres to our organizations' sound principles for reforming and improving the nation's healthcare system nor the federal law requirements it purports to interpret. As discussed in detail below, the guidance will make it easier for states to use federal taxpayer dollars to promote sub-standard plans that do not provide comprehensive and affordable coverage. This policy change tips the scales in favor of insurance products that are inadequate to meet the needs of millions of Americans with pre-existing conditions. We ask that HHS and Treasury rescind this guidance.

Protections for Vulnerable Populations

The 2015 guidance recognized that the ACA prohibits states from using the Section 1332 waiver program in a manner that would harm vulnerable residents, including older Americans, individuals with low incomes and those with serious health issues or who have a greater risk of developing serious health issues. Thus, while waiver applications have, until now, been evaluated based on their average impacts on all state residents, the evaluation process also has included the requirement that a waiver program ensure that the state's vulnerable residents are held harmless.

It is deeply troubling that the new guidance purports to do away with this safeguard. Notwithstanding statutory requirements, the guidance appears to condone waiver programs that make it harder for vulnerable residents to enroll in affordable, comprehensive coverage, so long as the state forecasts that more people may benefit from the program, or that the benefits for some are likely to be greater than the harm the waiver causes others.

These vulnerable populations – low-income individuals, older Americans and people with pre-existing conditions – are the patients and consumers our organizations represent, and they rely on the ACA's protections in order to access quality and affordable healthcare. These individuals often do not have other options to purchase quality and affordable healthcare coverage. Without the ACA's protections, including premium rating rules, the essential health benefits and prohibition of annual and lifetime limits on covered care, patients with pre-existing conditions would face a market that does not offer the coverage they need to manage their health, regain or maintain optimal health and productivity and

achieve better health outcomes. Additionally, absent these important protections, older Americans would face a market with unaffordable premiums and sub-standard coverage. Yet the guidance encourages states to pursue waivers likely to make these populations worse off. This is unacceptable.

Accessibility

The new guidance does not meet the standard of ensuring that coverage is accessible to patients and families.

The ACA is designed to encourage enrollment in minimum essential coverage (MEC)—a term created by and defined in the Act. While, for example, individual health insurance compliant with the ACA’s market reforms, as well as most job-based coverage, qualify as MEC, products such as short-term, limited-duration insurance, which is exempt from all of the ACA’s consumer protections, does not. Consistent with this statutory structure, the 2015 guidance stated that a waiver application must be rejected unless a comparable number of state residents are forecast to have MEC under the state plan as would have MEC without it.

However, the new guidance rejects this understanding, impermissibly eroding the statutory guardrails and potentially increasing the cost of coverage for people with pre-existing conditions. Relying on a broad regulatory definition of insurance promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) — not the ACA — the guidance purports to allow states to satisfy the coverage guardrail by counting individuals enrolled in insurance products that do not comply with the ACA’s individual and small group market consumer protections.

The Administration’s interpretation, as further elaborated in its November 29, 2018 waiver concepts discussion paper, seems to permit states to take federal dollars intended to help people enroll in comprehensive coverage and use those funds instead to spur enrollment in substandard insurance products that actively discriminate against people with preexisting conditions. This suspect interpretation could lead to states adopting policies in which fewer people are enrolled in comprehensive coverage than could be expected to have done so absent the waiver, fundamentally changing the risk pool for such coverage. This type of change could lead to a bifurcation of the market and make comprehensive coverage unaffordable for patients who need it to manage pre-existing conditions like pregnancy, cancer and heart and lung disease.

Affordability

The new guidance encourages states to use 1332 waivers to implement policies that would reduce enrollment in affordable coverage.

The guidance asserts that, when evaluating whether a waiver meets the affordability and comprehensiveness guardrails, it does not matter whether state residents actually enroll in affordable, comprehensive coverage. Rather, it claims a waiver may be approved based simply on “the nature of coverage that is made available” to them. This so-called “access to coverage” standard flies in the face of the federal statute. Section 1332’s affordability guardrail requires that an approved waiver be forecast to “provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable” as would be provided under the ACA in the absence of the waiver. The plain meaning of the phrase “provide coverage” — which, notably, is twice repeated in the directly adjoining statutory text that articulates the other coverage guardrails — is to permit only those waivers that will result in at least as many people actually having affordable (and comprehensive) coverage as would without the waiver.

This gross misinterpretation of the guardrails will have real consequences for patients and consumers. People with pre-existing conditions or other medical needs must be enrolled in affordable, comprehensive coverage to get the care they need without incurring massive medical debt. Moreover, this guidance threatens to undermine the risk pool for people who need more robust coverage and drive up the cost of insurance for people with pre-existing conditions. CMS should approve a waiver only if it satisfies the statutory requirement that the number of people projected to enroll in affordable, comprehensive coverage under the waiver is the same or higher than what it would be absent the waiver.

Using the misinterpretation of the coverage guardrail expressed in the latest guidance, states could use federal taxpayer dollars to steer people into sub-standard coverage. But, for patients with health conditions like lung disease, cancer, pregnancy, heart disease, rare diseases and diabetes, such coverage is likely to be inaccessible or insufficient. For people who are healthy when they enroll in coverage, the limited protections offered by such products raise the risk that they will be hit with large bills for basic preventive services or emergency care.

The new guidance appears to break with the statute in other ways that are likely to make the patients we represent worse off. Recognizing the requirement that a waiver “provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable” as the ACA, the 2015 guidance stated that waiver applications would not be approved if they reduced the number of people with coverage that provides both an actuarial value (AV) equal to or greater than 60 percent and a maximum out-of-pocket limit compliant with the ACA. These protections against excessive cost sharing are notably absent in the new guidance. Instead, the waiver concepts discussion paper invites states to apply for waivers that would increase enrollment in short-term, limited-duration plans and other coverage options that typically do not provide 60 percent AV, do not have to include an out-of-pocket maximum and can even impose annual or lifetime limits on coverage. People with serious and chronic health conditions may need expensive medical procedures, use specialty medications or require other medically necessary services that can easily lead them to hit such coverage limits. Without these protections, patients could be subject to many thousands of dollars in medical expenses that put their financial stability and medical wellbeing at risk.

The new guidance also invites states to make changes to the ACA’s subsidy structure, which provides financial assistance to individuals with incomes between 100 and 400 percent of the federal poverty level (FPL). Such changes could have major implications for the affordability of coverage for patients with pre-existing conditions and other vulnerable populations. For example, under one option suggested in the waiver concepts discussion paper, states could change the current subsidy structure to a fixed per-member-per-month contribution to a health care account based on age. This type of arrangement would provide no financial protection to patients if healthcare premiums go up (as the current subsidy structure does) and could drastically change the affordability of coverage for low-income populations. Our organizations are deeply concerned about these types of changes and the impact they will have on access to care that is required to diagnose and treat life-threatening and chronic medical conditions.

Additionally, the new guidance specifically notes that the Internal Revenue Service (IRS) could administer a waiver that provides federal tax credits to individuals with incomes below 100 percent FPL in non-expansion states, which could deter states from pursuing the ACA’s Medicaid expansion to 138 percent FPL. Medicaid expansion has been critically important for patients with serious and chronic health conditions – providing coverage that includes essential health benefits like emergency care and

hospitalizations, expands access to preventive services like cancer screenings and tobacco cessation treatment at no cost, and includes important limits on individuals' cost sharing. Furthermore, in order to meet the federal deficit neutrality guardrail, financial assistance for other residents would need to be reduced, thereby increasing premiums and out-of-pocket costs for many consumers and putting the affordability of coverage for vulnerable patients at further risk.

Adequacy

Finally, the new guidance allows states to make changes that will reduce enrollment in the comprehensive coverage that patients with pre-existing conditions rely upon to manage their health conditions.

First, and as discussed above, the guidance's adoption of a so-called "access to coverage" standard suggests the agencies may approve a waiver that is forecast to reduce enrollment in comprehensive (and affordable) coverage. We believe this newly created test contravenes the plain language of the statute and by its nature would make patients with pre-existing conditions worse off. This change in the standard will also allow states to ignore and fail to address the barriers that prevent many individuals from actually obtaining coverage that may be available to them, such as language barriers, health literacy issues and lack of accessible and understandable information.

The new guidance incorporates changes to states' essential health benefits (EHB) benchmark plans that the Administration finalized in the Notice of Benefit and Payment Parameters for 2019 that allow states to design EHB benchmark plans that provide less generous coverage for individuals. Additionally, the new guidance allows states to design a hypothetical benefit package specifically for the purposes of its waiver application that is not reflective of the state's actual benchmark plan, and then use this — potentially skimpier — benefit package as the baseline for determining whether waiver coverage is sufficiently comprehensive. Patients with serious and chronic diseases rely on coverage that includes robust coverage of essential health benefits to access the preventive services, prescription medications, visits with primary care and specialist providers and other treatments and services that they need to manage their conditions and stay healthy. Allowing states to manipulate the standard for assessing the Section 1332 comprehensiveness requirement in this way could directly harm patients' care.

Both the guidance and the waiver concepts discussion paper discuss options for states to customize healthcare.gov. While states could use this flexibility to improve consumers' enrollment experience, the Administration is inviting states to use this option to promote non-ACA-compliant plans, like short-term, limited-duration plans and association health plans, side-by-side with ACA-compliant plans. Such waivers would provide significant risks to consumers — increasing confusion about the coverage provided and costs associated with different plans. For example, patients diagnosed with serious medical conditions could discover the coverage they chose exposes them to uncapped financial liability or does not cover the essential health benefits that they need to manage their condition or even receive life-saving treatment.

Lastly, the waiver concepts discussion paper suggests options for states to use 1332 waivers to establish high risk pools. While our organizations support reinsurance programs that help insurers to cover enrollees with high health care costs, we are deeply concerned about the use of high risk pools for patients with expensive health conditions. High risk pools have a long history of providing inadequate coverage for the patients we represent — including pre-existing condition exclusions, waiting periods, and lifetime limitsⁱⁱ — and we do not want to turn the clock back to the days when patients with pre-existing conditions were locked out of comprehensive, affordable coverage on the individual market.

Legal Issues

Our organizations believe that the interpretation of the ACA's statutory language under this guidance raises serious legal concerns. As others have noted, policy changes of this magnitude should go through a full rulemaking process.ⁱⁱⁱ The guidance clearly undermines many of the statute's guardrails and other provisions that protect patients with serious and chronic conditions.

First, the guidance provides the agencies with latitude to approve a waiver that is likely to *reduce* enrollment in affordable and comprehensive coverage, as long as the proposal merely estimates that a coverage option that is affordable and comprehensive will be available. This interpretation is clearly inconsistent with the statute, which requires that a plan be forecast to "provide coverage" that is affordable and comprehensive, not simply provide the "option of" such coverage.

Second, the guidance asserts that a waiver that reduces the number of people with MEC may be approved if it offsets those coverage losses with increased enrollment in insurance products that do not satisfy the market reforms of the ACA. In particular, the guidance adopts for its test of the coverage guardrail a broad regulatory definition of insurance derived from HIPAA, not the ACA, and that includes short-term, limited-duration coverage and association health plans that are not compliant with the individual and small group market reforms of the ACA. In effect, this approach allows states to waive provisions of the ACA — including protections for people with pre-existing conditions — that are, by the terms of the statute, not waivable, putting the patients we represent at risk.

Third, the guidance redefines "comprehensive," for the purposes of satisfying the comprehensive coverage guardrail, in a way that appears to lower the bar well below what the statute permits. The new definition allows a state to create a hypothetical, unapproved EHB package, which need not reflect the state's existing benchmark plan, and use this (potentially skimpier) benefit package as the baseline for determining whether waiver coverage is sufficiently comprehensive. To the extent this approach allows states to use a benefit package that is not actually "offered through" any ACA marketplace and that cannot be certified as comprehensive by the HHS Office of the Actuary, as required by the ACA, it is inconsistent with the statute.

Finally, the ACA requires a state applying for a 1332 waiver to "enact a law . . . that provides for State actions under a waiver under [Section 1332], including the implementation of the State['s] [waiver] plan." However, under the new guidance, a state can meet this requirement if it can point to (1) a law that provides general authority to enforce the ACA; and (2) more specific executive branch action (a regulation or executive order). This interpretation is at odds with the plain language of the ACA.

Conclusion

Our organizations represent millions of patients, individuals, caregivers and families who need access to quality and affordable healthcare coverage. Our organizations are deeply concerned that the new guidance undermines the plain language of Section 1332 of the ACA and its protections for patients with serious, acute, and chronic conditions. The new guidance does not meet our standards for affordable, accessible and adequate coverage and puts the individuals that we represent at financial and medical risk. We therefore urge HHS and Treasury to immediately withdraw the proposed guidance. Thank you for the opportunity to provide comments.

Sincerely,

Adult Congenital Heart Association
American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Global Healthy Living Foundation
Hemophilia Federation of America
Immune Deficiency Foundation
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
WomenHeart: The National Coalition for Women with Heart Disease

CC: The Honorable David J. Kautter, Assistant Secretary for Tax Policy
U.S. Department of Treasury

The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

ⁱ American Heart Association website, “Healthcare reform principles.” Available at:

http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

ⁱⁱ Pollitz, Karen. High Risk pools for Uninsurable Individuals. Kaiser Family Foundation. February 22, 2017. Available at: <https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/>.

ⁱⁱⁱ Christen Linke Young, Brookings Institution, “The Trump administration side-stepped rulemaking processes on the ACA’s State Innovation Waivers—and it could make their new section 1332 guidance invalid.” Available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/11/28/the-trump-administration-side-stepped-rulemaking-processes-on-the-acas-state-innovation-waivers-and-it-could-make-their-new-section-1332-guidance-invalid/>.