July 31, 2021

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
United States House of Representatives
Washington, D.C. 20515

The Honorable Patty Murray
Chair
Committee on Health, Education, Labor & Pensions
United States Senate
Washington, D.C. 20510

RE: Request for Information on Design Considerations for Legislation to Develop a Public Health Insurance Option

Dear Chairman Pallone and Chair Murray,

On behalf of the National Health Law Program (NHeLP), we offer this response to your request for information (RFI) on design considerations for legislation to develop a public health insurance option. For over fifty years, NHeLP has worked to protect and advance the health rights of low-income and underserved populations. We advocate, educate, and litigate at the federal and state levels to advance health and civil rights in the U.S. Our work is guided by the belief that health care is a fundamental right. We believe that every person should have meaningful access to affordable, comprehensive, and quality health care free from discrimination, regardless of their income, race, gender identity, sex, ethnicity, language, immigration status, sexual orientation, disability status, or state or U.S. territory of

residence. We share your ultimate goal of achieving universal health coverage. NHeLP previously developed a set of *Universal Health Care Guideposts and Principles* for evaluating universal health care reform proposals. Building on that foundation and our overarching efforts at NHeLP, we offer the following responses. Given our focus on protecting and strengthening Medicaid for low-income and underserved communities, we begin by addressing how any public option approach should interact with Medicaid. We then discuss how a public option should structure benefits and address health inequities.

Response to Question 7: How should the public option interact with public programs including Medicaid and Medicare?

A. If relying on Medicaid, the public option should guarantee protections and coverage levels for current enrollees

As a guiding principle, NHeLP unequivocally opposes any reform proposal that leaves Medicaid enrollees worse off than their current status. Because of the particular needs of low-income enrollees and other underserved populations, proposals that implicate, in any way, the Medicaid program should explicitly guarantee the benefits and protections that currently exist for low-income populations in Medicaid, so that current enrollees are not harmed by the implementation of a public option. For example, public option proposals should ensure that at no time Medicaid populations are asked to subsidize non-Medicaid public option enrollees. We have continuously raised this concern in states that have explored the possibility of implementing Medicaid buy-in programs that require combining current Medicaid- and public option-eligible individuals into one single coverage pool.[1] This type of public option has the potential to increase overall costs in Medicaid by, intentionally or unintentionally, altering the Medicaid risk pool (*i.e*. the group of individuals insured).[2]

A federally facilitated public option does not necessarily implicate the Medicaid program and we acknowledge that many current public option proposals rely instead on Marketplace coverage as a starting point. Nonetheless, we believe public option proposals should incorporate certain guardrails that protect low-income people currently enrolled in the Medicaid program, particularly when considering a public option program that mirrors Medicaid or if it uses the program's coverage, provider network, and pool.

[1] Jennifer Lav & Héctor Hernández-Delgado, *State Medicaid Buy-Ins: Implications for Low-Income Enrollees*, Nat'l Health Law Prog. (Feb. 2018).
[2] *Id.*

The size and diversity of a health insurance risk pool determines how health care costs are distributed across a group.[3] In general, the bigger the risk pool, the easier it is to spread the high cost of one individual's serious needs across a broader population. In a managed care context, a bigger risk pool may mean a state can negotiate a lower per member per month rate. If public option enrollees are healthier than those already covered by Medicaid, merging the traditional Medicaid risk pool with the public option risk pool could lower overall costs to the state. A public option carefully designed in this way may in fact improve the conditions of current Medicaid enrollees because state budget pressures to restrict eligibility or services could be lessened. However, if the public option population is costlier than the current Medicaid risk pool, it could increase the overall cost of the program. This could in effect lead to Medicaid subsidizing health care for the public option population in a way that threatens the financial stability of Medicaid for lower-income individuals and families.

The scenario in which Medicaid enrollees subsidize the care of higher income individuals is particularly plausible if the benefits offered to public option enrollees are the same as traditional Medicaid coverage. Because Medicaid coverage is typically better than Marketplace coverage, it might reasonably attract individuals with significant health conditions. Some proponents of Medicaid buy-ins have suggested doing this intentionally—shifting expensive enrollees into Medicaid's risk pool (and by default converting Medicaid into a de facto high-risk pool) to reduce premiums in private insurance risk pools. By allowing individuals with significant needs to "use" Medicaid's risk pool, however, public option proposals that expand Medicaid eligibility to higher income populations (or allow higher income individuals to buy into the program) could have the effect of lowering the costs for private insurance while adding costs to the Medicaid program.[4]

NHeLP firmly believes that benefits provided to public option enrollees should be as comprehensive as possible (see below). However, we urge Congress to evaluate the extent to which better coverage through combined risk pooling would inevitably increase overall costs in Medicaid that could subsequently lead to potential cuts in current Medicaid

[3] Linda Blumberg & John Holahan, *Don't Let The Talking Points Fool You: It's All About The Risk Pool*, HEALTH AFF. (Mar. 15, 2016).
[4] See Robin Rudowitz, Rachel Garfield & Elizbateh Hinton, *10 Things to Know about Medicaid: Setting the Facts Straight*, Kaiser Family Found. (May 9, 2017), (stating that Medicaid acts as a high-risk pool by covering a population with high rates of disease and disability compared to the population covered by private insurance).

coverage and imposition of barriers to accessing care. Many states are currently experiencing rising health care costs, both because of investments in pandemic response and because of the increases in health care costs that predated the pandemic and have continued to date. States are also experiencing budget crunches because of the impact the pandemic has had on their economies. In response, some states have already resorted to cutting back on the amount they spend on health care, and some have proposed cuts to their Medicaid programs.[5] These budget cuts could have the effect of reducing eligibility for certain currently eligible populations, eliminating coverage for certain non-mandatory services, imposing utilization management controls that limit access to services, and reducing provider rates, all of which harm current Medicaid enrollees.

If not carefully designed, a public option that uses Medicaid could end up exacerbating current budget constraints. As such, we urge Congress to consider the likelihood that extending Medicaid eligibility to higher income populations without proper financial guardrails could lead to unintended harmful consequences for current enrollees. Public option proposals that intend to utilize the Medicaid program should always incorporate necessary guardrails to ensure that current protections and levels of care are maintained.

B. The public option must comply with the Affordable Care Act's "No Wrong Door" Policy

The Patient Protection and Affordable Care Act (ACA) requires states to put in place an application system whereby individuals can fill out one single and streamlined application and be assessed for eligibility in the different health insurance programs. This "No Wrong Door Policy" should apply to the public option program regardless of whether it uses Medicaid as a starting point or consists of a new individual plan to be sold in the Marketplace. If the public option is incorporated into the Medicaid program, applications should assess whether the person is eligible for regular Medicaid first, and if not, the person should be assessed for eligibility in the public option program. If not eligible for regular Medicaid but eligible for the public option, the person should be given the opportunity to buy into the public option program rather than automatically be referred to the Marketplace. Similarly, if the public option is offered as an additional option in the Marketplace, the system should be able to assess eligibility for the program through the streamlined application process already in place.

[5] Aviva Aron-Dine, Kyle Hayes & Matt Broaddus, *With Need Rising, Medicaid is at Risk for Cuts*, Ctr. on Budget and Policy Priorities (July 2020).

Response to Question 4. How should the public option's benefit package be structured?

A. Benefits must be comprehensive

Any public option approach must cover comprehensive health benefits. A public option should meet all of enrollees' health care needs without annual or lifetime limits. If the public option enables people who would not otherwise be eligible to purchase coverage through Medicaid, then its benefits plan must meet all Medicaid State plan requirements. If Congress pursues a public option offered through the Marketplace, the benefits package must include all Essential Health Benefits (EHBs) and, for lower income enrollees, incorporate key Medicaid protections as well.

People with low incomes, particularly Black, Indigenous, and other people of color (BIPOC), lesbian, gay, bisexual, transgender, queer, and gender-nonconforming people (LGBTQ-GNC), and people with disabilities, often lack health insurance and experience urgent, persistent, and complex health care conditions. They are more likely than people with higher incomes to have a substantial mix of chronic, behavioral, or acute health conditions. Medicaid covers a variety of services that address these health complex needs and are not traditionally covered by private health plans. Mandatory Medicaid services provide a mix of primary and specialty services tailored to these needs, such as home health services, nursing facility services for enrollees 21 or over, the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) benefit for people under age 21, key reproductive and sexual health services, Rural Health Clinic services, Federally Qualified Health Center services. They must provide non-emergency medical transportation, addressing a key determinant of health care access that is often out of reach for people with low incomes.

Additionally, State plans cover a number of optional services including service delivery reforms that strengthen behavioral care, chronic health condition management, and primary care integration (*e.g.,* Patient Centered Medical Homes, Medicaid Health Homes, Assertive Community Treatment, and supportive housing services); vision, hearing, and dental services; and personal care services. All cover outpatient prescription drugs. Many cover vital mental health and substance use disorder services, home and community-based services. Any Marketplace-based public option available to people with low incomes must include the full scope of mandatory and critical optional Medicaid services (*see, e.g.*, those

discussed above). Medicaid's comprehensive benefits are particularly important for the many low-income people with disabilities or living with or at risk of chronic health conditions.

i. Sexual and reproductive health services

Comprehensive health coverage cannot be achieved without including the full range of sexual and reproductive health services. Any public option approach must incorporate coverage of preventive services as defined by the ACA (*e.g.*, contraception, screenings for HIV and other sexually transmitted infections, and preexposure prohylaxis to reduce the risk of HIV transmission for people considered at high risk of HIV infection), pregnancy-related care, abortions, unbiased and medically accurate counseling, HIV viral suppression medications, and gender-affirming care.

Decades of evidence demonstrate that denying coverage for, and in effect, access to vital sexual and reproductive health services exacerbates health inequities. For example, as global and national health authorities such as the United Nations, World Health Organization, and American College of Obstetricians and Gynecologists attest, abortion is a safe and essential health care service and access is a human right. Current abortion coverage restrictions such as the Hyde Amendment force people to carry pregnancies to term against their will and place people at greater risk of experiencing severe and long-lasting negative health outcomes. People who give birth after being denied abortion access report more chronic pain and rate their overall health status as worse. People who are denied abortion access experience more potentially life-threatening complications, such as preeclampsia and postpartum hemorrhage, than if they had received abortions. The risk of death associated with carrying a pregnancy to term is, on average, about fourteen times higher than that with abortion. People who are denied abortions are also at risk of death from conditions that are more fatal for pregnant people. For example, a woman who was denied an abortion and enrolled in the Turnaway Study died from a condition that presents a higher risk of death among pregnant people. Including abortion coverage restrictions in any public option configuration would perpetuate the U.S.' Black and Indigenous maternal mortality epidemic. Public options must not incorporate any such restrictions on sexual and reproductive health coverage.

ii. Additional considerations for Marketplace-based proposals: strengthening essential health benefits

Implementing a public option provides an opportunity for Congress to address gaps in coverage and to ensure that individuals accessing the new program get coverage for a comprehensive set of benefits. Before pursuing a Marketplace-based approach, we ask that Congress address gaps that have remained in the individual market despite coverage of EHBs. We understand that to create a public option that can compete with private plans, the set of covered benefits should be standardized and comparable as much as possible to benefits covered by other plans. As such, we ask that Congress use this opportunity not only to create a public option that improves upon coverage of EHBs and addresses remaining gaps, but also to extend those improvements to other plans in the Marketplace by implementing new necessary coverage requirements or improving enforcement of current ones.

For example, even though the Department of Health and Human Services has adopted minimum definitions for coverage of rehabilitative and habilitative services, individuals continue to experience difficulty accessing medically necessary services that fall under this category. One of the most prominent examples of this gap is hearing aids, coverage of which continues to be limited in the Marketplace throughout the country.[6] As with other services, hearing aid coverage is often limited to certain devices, such as cochlear implants. The Ninth Circuit has already found that categorically limiting coverage of hearing aids in this way may constitute a violation of plans' obligations under Section 1557 of the ACA.[7]

Similarly, while EHBs appropriately require coverage of mental health and substance use disorder services (MH/SUD), most people who need these services continue without access.[8] One of the biggest issues with MH/SUD coverage in the Marketplace is the lack of enforcement of federal parity requirements.[9] While the current administration has taken some steps to mitigate these issues, Congress must ensure that any public option proposal

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[6] HearingLikeMe, A State-by-State Guide for Hearing Aid Insurance (last visited July 30, 2021).
[7] *Schmitt v. Kaiser Found. Health Plan of Was.*, 965 F.3d 945 (9th Cir. 2020).
[8] Substance Abuse and Mental Health Servs. Admin. (SAMHSA), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (2020).
[9] U.S. Gov. Accountability Office, *GAO 20-150, Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements* (2019).

includes strict requirements to comply with both coverage and parity mandates. In addition, because the quality of services provided is as important as coverage of those services, we ask that the benefit package of a public option provide for coverage of the whole continuum of care for people with MH/SUD conditions. In particular, we emphasize the need to provide robust funding for home- and community-based services and to ensure that enrollees have access, at all times, to the lowest placement level of care necessary for their condition. As mentioned above, this should be addressed for both the public option plan as well as other marketplace plans.

Another category where EHB coverage has failed to meet all needs is coverage of pediatric services. For example, a 2019 study found that while EHBs expanded coverage of pediatric dental services, the inclusion of the services in the benefit package has not resulted in increases in the number of Marketplace kids accessing the services.[10] Thus, we believe any public option plan must cover pediatric services, including oral and vision care, but coverage for kids should be expanded beyond the EHB requirements to ensure proper access to necessary care. We urge Congress to recognize the need for comprehensive coverage for minors and to require any public option plan to cover pediatric care that extends to the full array of medically necessary services for this population. In fact, to the extent possible, pediatric coverage in the Marketplace should mirror coverage under Medicaid's EPSDT benefit.

Finally, we remind Congress that the ten EHB categories represent a minimum standard and that many important services fall outside of these categories.[11] For example, we would urge Congress to use the opportunity afforded by the implementation of a public option to ensure that regardless of income, public option enrollees have access to additional services such as adult dental and vision care (currently barred from coverage under EHB requirements) and supportive services, which may include language access services, disability access services, case management, transportation, and other services to facilitate access to services.

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[10] Ashley M. Kranz & Andrew W. Dick, *Changes in Pediatric Dental Coverage and Visits Following the Implementation of the Affordable Care Act*, 54 HEALTH SERV. RES. 437 (2019).
[11] 42 U.S.C. § 18022(b)(1) ("The Secretary shall define the essential health benefits, except that such benefits shall include *at least* the following general categories and the items and services covered within the categories" (emphasis added)).

We reiterate the separate need for congressional and/or administrative action to improve coverage of EHBs for all Marketplace enrollees. Nonetheless, specific to this RFI, we request that any public option plan include such improvements as a minimum level of coverage. In fact, Congress could plausibly use the Medicaid benefit package as a minimum standard instead of EHBs, although we recognize that doing so could introduce significant differences between the public option and private plans that make the public option more difficult to financially sustain at private plan rates.[12] On the other hand, providing a better set of benefits without increasing out-of-pocket costs could attract a significant number of consumers and may lead private plans to improve their own coverage to better compete with the public option.

B. The public option must be affordable for everyone

Any public option proposal should stand by the principle that health care coverage must be affordable for all people, including especially those with lower incomes or who have higher than average health costs. Ensuring low premiums is only one key component of affordability. Numerous studies have demonstrated that for low-income families, even relatively low premiums cause a significant drop in enrollment.[13] In Indiana's Medicaid expansion program, the state-contracted evaluator found that 23 percent of otherwise eligible applicants did not actually begin coverage because they did not or could not pay the initial premium ($10 to $27, depending on their income). Although these people could reapply, only about half ever did so successfully.[14] This suggests that the Healthy Indiana Program's "payment before benefits" provision alone kept 11.5 percent of the otherwise eligible applicants in that income group from ever participating.

Maintaining low premiums, while necessary, is not sufficient to guarantee affordability. Deductibles, co-pays, and other cost sharing often also create barriers to accessing care for

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[12] Heidi Allen et al., *Comparison of Utilization, Costs, and Quality of Medicaid vs. Subsidized Private Health Insurance for Low-Income Adults*, JAMA NETWORK OPEN (Jan. 5, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774583 (finding that that overall health care spending was 80 percent higher among Marketplace-eligible adults than among Medicaid eligible adults).

[13] *See, e.g.*, Samantha Artiga et al., Kaiser Fam. Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017). David Machledt & Jane Perkins, Nat'l Health Law Prog., *Medicaid Premiums & Cost Sharing and Premiums* (March 2014).

[14] *Id.* at 12.

a public option. Lower income families are more likely to avoid necessary services due to cost sharing.[15] Even very low-cost sharing has proven to reduce access to medications and other services for people with very low-incomes.[16] Generally, premiums and out-of-pocket costs should be nominal or non-existent for low-income populations.[17] First dollar coverage helps people with disabilities and others who need access to care and treatment on a routine basis have predictable and affordable co-pays. Deductibles should be reduced or eliminated, especially for those with lower incomes. Not only have deductibles proven to reduce access to necessary care, but they do so indiscriminately, with enrollees just as likely to skimp on high value, effective treatments as low-value care.[18] That means people may ration their medications, or delay preventive care that later leads to poorer outcomes and more expensive treatment.

The notion that blanket cost sharing policies like deductibles and coinsurance lead to more "shopping for care" is a fallacy. Enrollee awareness of the specifics of their cost sharing structures, such as which services are exempt from a deductible, is typically very low.[19] It is extremely difficult to find out up front what the ultimate cost of care might be, so consumers tend to avoid services they can out of concern for high costs. People with disabilities and chronic conditions often have higher than average out of pocket medical expenses and so are most likely to have to make these difficult decisions to self-ration their care, which can lead to poorer outcomes and more expensive care episodes down the road.[20]

If the public option proposal runs through Medicaid, then the public option's affordability protections should be at least as strong as Medicaid's robust cost sharing and premium

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[15] Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 ARCHIVE OF INTERNAL MED. 1918 (2010).
[16] Leighton Ku, Elaine Deschamps & Judi Hilman, *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program* 1 (2004).
[17] In all, 57,189 of roughly 195,000 who ever faced a required premium were disenrolled or not enrolled due to nonpayment at least once. Lewin Group, Indiana HIP 2.0: POWER Account Contribution Assessment, ii (Mar. 31, 2017).
[18] Zarek C. Brot-Goldberg et al., *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, NBER DIGEST (2015); Noam N. Levy, *Health Insurance Deductibles Soar, Leaving Americans with Unaffordable Bills*, LOS ANGELES TIMES, May 2, 2019.
[19] Mary E. Reed et al., *High-Deductible Health Insurance Plans: Efforts to Sharpen a Blunt Instrument*, 28 HEALTH AFF. 1145–54 (2009); see also, *id.*
[20] Amal N. Trivedi, Husein Moloo & Vincent Mor, *Increased Ambulatory Care Copayments and Hospitalizations among the Elderly*, 362 NEW ENGLAND JOURNAL OF MEDICINE 320–8 (2010).

limitations. If done through another mechanism, the public option can avoid some of these pitfalls by taking three major steps to ensure affordability and transparency in cost sharing policy:

(1) **Create a simple, standardized cost sharing structure with low or no deductibles, no coinsurance, limited co-pays, and a low out-of-pocket (OOP) maximum.** Standardized cost sharing plans have proven effective to help consumers determine their likely overall expenses. Low OOP maximums shield people with high care needs or expensive, unexpected developments from financial ruin.

(2) **Avoid blunt cost sharing structures like deductibles and coinsurance that lead to indiscriminate care rationing.** In theory, cost sharing is meant to encourage prudent use of health care and to steer individuals away from low-value services**.** In practice, though, enrollees tend to reduce (or fail to initiate) wherever they can. If that means splitting their heart medication dose in half so they can make rent this month, that is what people do. Avoiding these blunt utilization tools would be a positive step forward for any public option.

(3) **Reduce burdensome utilization management techniques that function primarily as cost-control mechanisms.** Utilization management tools like cost sharing, prior authorization, and step therapy create barriers to needed care that often have little to do with therapeutic value. Utilization management disproportionately impacts people with disabilities and chronic conditions who frequently need high-cost high-intensity care and do not have lower-cost alternatives. Many states eased or eliminated prior authorization during COVID-19, and this did not lead to an explosion of health care usage. It is a perfect time to analyze data from this experience and reconsider the frequent application of prior authorization, cost sharing, and other utilization management techniques as barriers to needed services, rather than a tool to improve care quality.

Response to Question 8: What role can the public option play in addressing broader health system reform objectives, such as delivery system reform and addressing health inequities?

Our country is marked by sustained imbalances in the allocation of power and resources, from voting rights to health care access, that are rooted in systems of oppression such as racism, gender-based discrimination, ableism, and xenophobia. As the COVID-19 pandemic, Black and Indigenous maternal mortality epidemic, and Southern Black HIV epidemic all lay bare, these imbalances create stark health inequities. People with lower incomes—particularly BIPOC, LGBTQ-GNC, people with disabilities, women, and people with limited English proficiency (LEP)—bear the brunt.

Any federal health care reform proposals, including public options, must center health equity in policy design, implementation, and beyond. They must account for and actively work to dismantle these inequities through actions such as:

(1) **Providing robust protections against discrimination in health care.** Discrimination within and beyond the health care system contributes to the U.S.' vast health inequities. Section 1557 of the ACA was central to ensuring that related reforms would benefit everyone in the U.S., regardless of race, color, national origin (including language and immigration status), age, sex (including sexual orientation, gender identity, and sex stereotypes), and disability.[21] Legislation should ensure that the public option is subject to Section 1557 so that enrollees can receive its critical protections.

(2) **Not excluding people from health coverage based on immigration status.** Immigrants comprise the largest group of uninsured people in the U.S.[22] Past efforts to advance universal access to affordable health coverage have largely left noncitizen immigrants living in the U.S. behind.[23] The categorical exclusion of immigrants from health coverage (*e.g.*, the Personal Responsibility and Work Opportunity Reconciliation Act's five-year bar on Medicaid and CHIP for most lawfully

[21] 42 U.S.C. § 18116.
[22] *See*, *Health Coverage of Immigrants*, Kaiser Family Foundation (Jul. 15, 2021).
[23] *See, e.g.*, Randy Capps & Michael Fix, I*mmigration Reform: A Long Road to Citizenship and Insurance Coverage*, 32 HEALTH AFF. 639, 639 (2013) (noting that "unauthorized immigrants will still be frozen out" of the ACA's health coverage gains).

present residents and ACA's complete ban on Marketplace coverage for people without status) is xenophobic and perpetuates uninsurance and health inequities for immigrants and their families, especially BIPOC. Congress must ensure that any public option is inclusive of people regardless of immigration status. Otherwise, Congress will gravely undermine potential gains in access to affordable coverage for all and health equity.

(3) **Meeting the health coverage needs of potential enrollees in the U.S. territories.** Congress should address the disparate treatment of residents of U.S. territories when it comes to the different health care programs that involve federal funding. As with Medicaid and Medicare funding, private insurance in the individual market remains unaffordable for most people living in the territories. Unaffordability is exacerbated by the fact that the ACA exempts territories from establishing either federally facilitated or state-run Marketplaces (or risk losing additional Medicaid funding) and by the lack of availability of advance premium tax credits and other consumer protections in the territories' individual markets.[24] We urge Congress to make any public option available to the territories and their residents and consider the need to expand affordability and coverage protections for people in the territories in order to reduce inequities among these mostly-BIPOC populations.

(4) **Appropriately addressing the social determinants of health.** Health is more than health care. Societal, political, and economic conditions have a profound impact on health. Health care, including Medicaid, the Marketplace, and any public option approach should appropriately address these determinants. It must embrace case management, which can help enrollees access needed health care, social, and other services, as an essential health care service. In addition, connected and coordinated health care and health-related social services are necessary to prevent amenable morbidity and mortality, promote a healthy population, and alleviate health inequities. Public options should cover screening for unmet physical, behavioral, and health-related social needs, such as food security and housing stability. While a public option cannot end societal problems such as gun violence, it should cover and ensure access to health care treatments that address current and accumulated health harms from unmet social needs. It should also cover and ensure access to navigation to services that address health and health-related social needs within and

[24] 42 U.S.C. § 18043.

beyond the health care system.

(5) **Prioritizing community engagement and participatory parity.** The people closest to the problems are closest to the solutions. Meaningful progress toward universal coverage and a more equitable society is not possible without ensuring that the voices of enrollee populations who bear the brunt of health inequities—especially BIPOC, LGBTQ-GNC people, and people with disabilities with lower incomes—are recognized and centered as decision makers in policy development, priority-setting, and implementation. This requires publicizing opportunities for community participation and providing compensation to enable that participation.

NHeLP greatly appreciates the opportunity to provide input in response to this RFI. We hope this information is useful and would welcome the opportunity to provide additional details or clarification. We are available to answer any follow-up questions or to provide additional information.

Sincerely,

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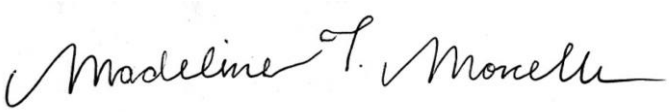

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