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July 28, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P, P.O. Box 8016
Baltimore, MD 21244-8016

**RE: RIN 0938-AU60; CMS-9906-P
Updating Payment Parameters, Section 1332 Waiver
Implementing Regulations, and Improving Health Insurance
Markets for 2022 and Beyond Proposed Rule**

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) has worked to improve health access and quality through education, advocacy and litigation on behalf of low income and underserved individuals for over fifty years. We appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule - Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond (hereinafter "UPP Rule").¹

We support many of the proposals in the UPP Rule which will expand enrollment opportunities, reduce the number of uninsured persons, and restore important Affordable Care Act (ACA) programs and protections. However, we object to the truncated thirty-day comment period. We also strongly object to designating the comment period from the posting of the public inspection version, and not the actual Notice of Proposed Rulemaking published in the Federal Register. This practice undermines the intent and purpose of the Administrative Procedure Act and must not become the norm in rulemaking.

Enrollment Opportunities in Health Care Marketplaces

CMS proposes several changes to improve and expand enrollment opportunities in Marketplace plans. We strongly support these changes, which include extending the open enrollment period and establishing a Special Enrollment Period (SEP) for low income persons. According to the Congressional Budget Office, more than one-third of people who are uninsured are, in fact, eligible for Medicaid or for premium tax credits (PTCs) in the Marketplace.² These strategies will go a long way to reduce the number of people who are uninsured.

Guaranteed Availability of Coverage - § 147.104

CMS says that it is reconsidering its interpretation that persons who owe past due premiums are prohibited from enrolling in coverage until they satisfy arrearages.³ We strongly support revising this unlawful interpretation of the guaranteed availability provision. The statute is clear – an issuer “must accept every employer and individual in the State that applies for such coverage.”⁴ This policy has created significant hardship for individuals. For example, some consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer’s account, issued bills that did not match the amount consumers were supposed to pay, and or engaged in other accounting irregularities that were of no fault of the consumers.

We recognize the adverse selection potential for beneficiaries to only enroll in and pay premiums for care when it is needed. Therefore, we support measures that allow issuers to recoup unpaid premiums while still maintaining beneficiary enrollment. Issuers are required by law to accept an enrollee who makes an appropriate application for coverage during an open or special enrollment period, regardless of past due premium payments. We strongly urge CMS to reconsider this ill-conceived and harmful interpretation of the ACA’s guaranteed issue requirements and help protect consumers from unlawful coverage losses.

¹ U.S. Dept. of Health & Human Svcs., Ctrs. for Medicare & Medicaid Svcs., U.S. Dept. of Treasury, Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule, 86 Fed. Reg. 35156 - 35216 (July 1, 2021), <https://www.govinfo.gov/content/pkg/FR-2021-07-01/pdf/2021-13993.pdf>.

² Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under 65: 2020-2030,” September 29, 2020, <https://www.cbo.gov/publication/56571>.

³ 86 Fed. Reg. 35162; *citing to* CMS Market Stabilization Final Rule, 82 Fed. Reg. 18346 (April 18, 2017), <https://www.govinfo.gov/content/pkg/FR-2017-04-18/pdf/2017-07712.pdf>.

⁴ 42 U.S.C. § 300gg–1(a).



Addressing DACA Eligibility - 45 CFR § 152.2

While not raised in the UPP Rule, we urge CMS in the final rule to end the exclusion of Deferred Action for Childhood Arrivals (DACA) recipients from the definition of lawfully present for the purposes of eligibility for marketplace coverage. We also urge it to clarify that individuals granted Special Immigrant Juvenile Status (SIJS), in addition to those applying for that status, are lawfully present for the purposes of ACA coverage, given that SIJS recipients are facing green card backlogs that weren't considered when the original regulation was drafted.

Executive Order 14009 states that it is the policy of the administration, "to make high-quality healthcare accessible and affordable for every American."⁵ Executive Order 13985 directs agencies to, "recognize and work to redress inequities in their policies and programs that serve as barriers to equal opportunity."⁶ The need to address DACA recipients' ineligibility for ACA coverage sits directly at this intersection. CMS could take action immediately to expand coverage to hundreds of thousands of disproportionately uninsured people who are primarily from communities of color.

The recent court ruling blocking the processing of first-time, initial DACA requests only increases the urgency of addressing this issue. While ultimately Congress must create a pathway to citizenship for those covered by the DACA program, the heightened sense of precariousness created by the ruling underscores the need for the federal government to address their stability and well-being. For example, having access to mental health services could be essential for many currently uninsured and increasingly uncertain immigrant youth.

Particularly in the context of the pandemic, where lack of access to health insurance can be deadly or result in bankrupting medical bills, it is important to ensure that everyone has access to coverage. A Kaiser Family Foundation study found that nearly two in five people who have or are likely eligible for DACA are uninsured, more than four times higher than the national uninsured rate.⁷ This data was pre-pandemic, and that rate may be much higher now, given that DACA recipients who lost their job due to the recession would have been unable to secure alternative public health coverage options. The same study also found that seventy percent of

⁵ Exec. Order No. 14009, "Strengthening Medicaid and the Affordable Care Act," 86 Fed. Reg. 7793 (Jan. 28, 2021), <https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicaid-and-the-affordable-care-act>.

⁶ Exec. Order No. 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," 86 Fed. Reg. 7009 (Jan. 20, 2021).

⁷ "Key Facts on Individuals Eligible for the Deferred Action for Childhood Arrivals (DACA) Program," Kaiser Family Foundation (Feb 1, 2018), <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-individuals-eligible-for-the-deferred-action-for-childhood-arrivals-daca-program/>.



those people are in good health, meaning that their longer-term impact on marketplace plan premiums will be positive.

Given that a large number of DACA recipients are front-line workers, the short-term need to ensure they have coverage is critical.⁸ For example, the Association of American Medical Colleges and thirty-two allied organizations filed an amicus brief in a DACA case, explaining that DACA recipients are a crucial part of their medical staffs and are needed to address shortages in underserved areas, particularly in the event of a pandemic.⁹ Unless CMS acts as soon as possible to address the arbitrary exclusion of DACA recipients from the lawfully present definition, hundreds of thousands will face a possible COVID resurgence this fall unnecessarily uninsured.

Expanded open enrollment - § 155.410

CMS proposes to extend the annual open enrollment period for the Federally Facilitated Marketplaces (FFMs) to January 15. We support this change and urge CMS to extend the deadline even further. As states' experience has shown, extending open enrollment greatly benefits consumers and helps reduce the number of uninsured. Currently, twenty percent of all individuals enrolled in Marketplace coverage live in states with extended enrollment periods beyond the current FFM deadline of December 15:¹⁰

- California and New Jersey have open enrollment periods that end January 31 with coverage starting February 1;
- Washington DC and New York also have Open Enrollment Periods (OEPs) ending January 31, but with coverage starting March 1;
- Massachusetts and Rhode Island have OEPs ending January 23, with coverage starting February 1.¹¹

⁸ Prchal Svajlenka, Nichole, *A Demographic Profile of DACA Recipients on the Frontlines of the Coronavirus Response*, Center for American Progress (Apr. 6, 2020), <https://www.americanprogress.org/issues/immigration/news/2020/04/06/482708/demographic-profile-daca-recipients-frontlines-coronavirus-response/>.

⁹ *Department of Homeland Security, et al. v. Regents Of The University Of California, et al.*, Brief amicus curiae of Association of American Medical Colleges, et al. (Oct. 8, 2019), <https://www.aamc.org/system/files/2019-10/ocomm-ogr-DACA%20Amicus%20Brief-10082019.pdf>

¹⁰ KFF, State Health Facts, Marketplace Enrollment, 2014 - 2021, 2021, <https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited July 16, 2021).

¹¹ CA. Legis. Assemb. AB1309. Reg. Sess. (2019-2020), https://leginfo.ca.gov/faces/billStatusClient.xhtml?bill_id=201920200AB1309; Get Covered NJ, Frequently Asked Questions, <https://nj.gov/getcoverednj/findanswers/faqs/>; DC Health Link,



We recommend CMS extend open enrollment to January 31 in the FFMs, and require coverage to begin February 1.

Applying for health insurance and selecting a plan can be challenging and has significant impact on an individual's and family's finances and health. For many consumers, buying health insurance is one of the most complicated, and consequential, financial decisions they make, second only to buying a car or a house. Requiring people to make these important and complicated decisions in just a few weeks during the holiday season can make it more difficult to get the best coverage.

Extending open enrollment to January 31 would be especially valuable for those who are automatically re-enrolled into coverage, but receive a lower subsidy than the prior year because the cost of their benchmark plan has dropped. These enrollees may have to pay a higher premium towards coverage despite staying the same plan. Because these consumers are automatically re-enrolled, they may not be aware of their higher premium contribution until they receive their bill in early January.

CMS asked for comments on creating a new SEP for current enrollees who are automatically re-enrolled and experienced a significant cost increase, and additional strategies such as targeted notices.¹² As noted below, SEPs can be complicated and difficult for some enrollees to access, so extending open enrollment beyond January 15 would be the preferred option. We agree that providing additional notice, plus improved consumer education, outreach, and assistance will help consumers.

Covered California reported a significant decrease in enrollment in 2019 when it changed the end date of open enrollment from January 31 to January 15; prompting the legislature to restore the January 31 deadline for the 2020 open enrollment period.¹³ According to the preliminary analysis of the 2020 open enrollment period, new enrollments increased by forty

Frequently Asked Questions, <https://dchealthlink.com/node/2413>; New York State Office of the Attorney General Health Care Bureau, Shopping for Health Insurance Helpful Tips for Open Enrollment 2020, https://ag.ny.gov/sites/default/files/health_insurance_shopping.pdf; Massachusetts Health Connector, 2021 Open Enrollment Social Media Toolkit, <https://www.mahealthconnector.org/wp-content/uploads/Health-Connector-Open-Enrollment-Social-Media-Toolkit-Nov2020.pdf>; Health Source Rhode Island, HealthSource RI extending Open Enrollment period to help more Rhode Islanders get health coverage for 2021, <https://healthsourceri.com/healthsource-ri-extending-open-enrollment-period-to-help-more-rhode-islanders-get-health-coverage-for-2021/>.

¹² 85 Fed. Reg. 35168.

¹³ AB 1309; Senate Rules Committee, Office of Senate Floor Analyses AB 1309, Aug. 29, 2019, https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB1309.



three percent.¹⁴ Even after subtracting the entire newly-enrolled 400 to 600% FPL population, Covered California’s new sign-ups in 2020 were still 36 percent higher than in 2019.¹⁵

During the period from 2017 - 2020, Covered California out-performed the FFEs in new enrollments, as demonstrated in the chart below:¹⁶

Table 2: Comparing Net Plan Selections in Federally-Facilitated Exchange States and California, 2016-2020

	Federally-Facilitated Exchange			Covered California		
	New Enrollment	Renewal	Total	New Enrollment	Renewal	Total
2016	3,984,426	5,553,411	9,537,837	425,484	1,149,856	1,575,340
2017	2,903,122	6,128,467	9,031,589	368,368	1,188,308	1,556,676
% change from previous year	-27.1%	10.4%	-5.3%	-13.4%	3.3%	-1.2%
2018	2,403,621	6,159,449	8,563,070	388,344	1,133,180	1,521,524
% change from previous year	-17.2%	0.5%	-5.2%	5.4%	-4.6%	-2.3%
2019	2,030,713	6,212,832	8,243,545	295,980	1,217,903	1,513,883
% change from previous year	-15.5%	0.9%	-3.7%	-23.8%	7.5%	-0.5%
2020	2,065,908	6,137,874	8,203,732	418,052	1,120,767	1,538,819
% change from previous year	1.7%	-1.2%	-0.5%	41.2%	-8.0%	1.6%
Cumulative Change	-48%	11%	-14%	-2%	-3%	-2%

* Analysis of FFE states includes the 32 states served by the FFE and the six states with state-based exchanges facilitated by the federal platform (SBE-FP). We exclude Kentucky and Nevada from all counts due to these states switching marketplace types in 2017 and 2020, respectively. All plan selection totals data for the FFE are from CMS public data releases; however, because the “new” and “renewing” splits for Kentucky are not yet available from CMS for 2020, Kentucky share of “new” versus “renewing” is estimated using the ratio for Kentucky from 2019.

New enrollments are “key to bringing in new and healthy risk that keeps premium lower.”¹⁷ CMS should adopt the best practices of Covered California leading to its success in new sign-ups, including extending the HealthCare.gov open enrollment period to January 31. New enrollment can reduce the number of uninsured and does not lead to adverse selection. Giving people more time to enroll means that more people can enroll in health coverage and select the plan that is best for them.

¹⁴ Covered California Executive Director’s Report, Peter V. Lee, Executive Director, March 26, 2020 Board Meeting (Mar. 26, 2021), Slide 33, <https://board.coveredca.com/meetings/2020/03%20-%20Mar%202020%20Meeting/PPT.ED%20Report.March%202020.3-26%20at%201.28pm%20-%20new%20call%20in%20info.pdf>.

¹⁵ *Id.*

¹⁶ *Id.* at slide 34.

¹⁷ *Id.*



Special enrollment period for low income persons - § 155.420

The UPP Rule would establish a new SEP for individuals and dependents who are eligible for advance premium tax credits (APTCs) and whose household income is under 150% of the federal poverty level (FPL). The low income SEP would allow those eligible to enroll at any time during the year based on their income or upon learning of their eligibility. We strongly support this proposal and urge CMS to expand the new SEP even further, to 200% FPL, which can help reduce the number of uninsured without resulting in adverse selection.

Data show that historically, SEPs can be so overly complex and restrictive that few of the people who qualify actually use SEPs.¹⁸ A new, year-round SEP for low income people would reduce the number of uninsured. Moreover, year-round enrollment for low income individuals would not lead to adverse selection where healthy people wait until they get sick to enroll in coverage. As experience from states shows, as well as the HealthCare.gov COVID-19 emergency SEP, people who receive significant help paying their premiums enroll in coverage when they can and are not an adverse selection risk. It is far more likely that they have delayed getting coverage because they were not aware it was an option, did not know that it was affordable for them, or unwittingly missed an earlier enrollment deadline.

Some states already provide year-round enrollment to people with income even higher than 150% FPL without any significant signs of adverse selection. In Massachusetts, people with incomes up to 300% FPL (about \$36,000 for an individual or \$75,000 for a family of four) can generally enroll in marketplace coverage year-round.¹⁹ New York and Minnesota allow year-round enrollment for people with incomes up to 200% FPL who are eligible for coverage through their Basic Health Programs (BHP), and insurers in those states say year-round BHP enrollment has not led to detectable adverse selection.²⁰ All three of these states have overall uninsured rates among the lowest in the nation.

¹⁸ Matthew Buettgens, Stan Dorn, and Hannah Recht, *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods*, Urban Institute, November 2015, <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>.

¹⁹ Sarah Lueck, *Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage*, CBPP (June 5, 2019), <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>.

²⁰ Jennifer Tolbert, Larisa Antonisse, and Stan Dorn, *Improving the Affordability of Coverage through the Basic Health Program in Minnesota and New York*, Kaiser Family Foundation, (Dec. 8, 2016), <https://www.kff.org/report-section/improving-the-affordability-of-coverage-through-the-basic-health-program-in-minnesota-and-new-york-issue-brief/>.



Data from 2020 COVID-related SEPs provided by states show that opening enrollment and reducing barriers to SEPs may actually attract younger and subsequently healthier enrollees.²¹ For example, Colorado's Marketplace had a higher proportion of enrollees under age thirty-five enroll when they opened an SEP for the uninsured during the COVID-19 pandemic, compared to enrollees who signed up during the annual open enrollment period.²² In the District of Columbia, as of August 30, 2020, enrollees ages eighteen to thirty-four made up fifty-three percent of all SEP sign-ups on the individual market, greater than the share of individual enrollees in that age range who signed up during the open enrollment period for 2020 (37.5%).²³ In Massachusetts, people enrolling through the COVID-19 SEP for the uninsured were more likely to be between the ages of eighteen to thirty-four than existing Marketplace members; forty percent were in this age range compared to thirty-two percent of all Marketplace enrollees.²⁴

In response to the COVID-19 pandemic, CMS established an emergency SEP that has allowed more than 1.5 million people to sign up for coverage via HealthCare.gov between February 15 and June 30.²⁵ The federal COVID-19 SEP shows that by easing restrictions and simplifying the SEP, HealthCare.gov can enroll more people in health coverage, some for the first time. We fully expect the final data from the federal COVID-19 SEP to show that adverse selection was not a factor influencing enrollment, particularly those who qualify for \$0 premium coverage.

The low income SEP will also help address health disparities by reducing the number of people of color who are uninsured. An estimated thirty percent of subsidy-eligible uninsured people are Hispanic, compared to twenty percent of the non-elderly U.S. population, and fifty-

²¹ Rachel Schwab and Sabrina Corlette, *Many States with COVID-19 Special Enrollment Periods See Increase in Younger Enrollees*, The Commonwealth Fund (Jan. 28, 2021), <https://www.commonwealthfund.org/blog/2021/many-states-covid-19-special-enrollment-periods-see-increase-younger-enrollees>.

²² Connect for Health Colorado, *COVID Special Enrollment Period Observations and Lessons Learned*, Board Committee Meetings (Sept. 28, 2020), <https://c4-media.s3.amazonaws.com/wp-content/uploads/2020/09/25064255/COVID-SEP-LL.pdf>.

²³ DC Health Benefit Exchange Authority, *Enrollment Summary as of August 31, 2020*, https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Enrollment%20data%20Sept%202020_0.pdf.

²⁴ Massachusetts Health Connector, *COVID-19 Special Enrollment Period: Final Enrollment Results* (Sept. 2020), <https://www.mahealthconnector.org/wp-content/uploads/Health-Connector-COVID-19-SEP-Brief.pdf>.

²⁵ Ctrs. for Medicare & Medicaid Svcs., *Press Release, Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline*, (July 14, 2021), <https://www.cms.gov/newsroom/press-releases/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-aug-15-deadline>.



nine percent of subsidy-eligible adults have a high school education or less, compared to thirty-six percent of non-elderly adults in the U.S.²⁶

In sum, we strongly support the year-round SEP for individuals and families as proposed and recommend HHS extend it to 200% FPL.

Direct Enrollment - § 155.221(j)

The UPP Rule would repeal a provision finalized in January 2021 allowing “direct enrollment exchanges,” which would circumvent the ACA Marketplaces and allow insurers and web brokers to operate enrollment websites through which consumers could apply for and enroll in coverage.²⁷ We strongly support repealing this provision. Direct Enrollment lacks key consumer protections and is contrary to the ACA’s “No Wrong Door” policy.²⁸ Moreover, as a recent report from the Leukemia and Lymphoma Society and approximately thirty other patient advocacy organizations exposed, web brokers often steer consumers to Short Term Limited Duration (STLD) plans, Health Sharing Ministries, and other health plans and insurance-like products that do not comply with key ACA protections including Essential Health Benefits.²⁹

Direct enrollment often precludes apples-to-apples comparison of plans because vendors can omit premium and cost-sharing information and use plan display features to bias plan selections according to which issuers pay the largest commissions. Issuers that act as web brokers can exclude all competing plans without even notifying the consumer of the omissions.

Further, brokers and insurers have no incentive to provide information and assistance to consumers who turn out to be eligible for Medicaid or the Children’s Health Insurance Program (CHIP) rather than subsidized Marketplace coverage. By preventing consumers from using HealthCare.gov and requiring them to rely on entities with a poor track record of facilitating

²⁶ Daniel McDermott and Cynthia Cox, *A Closer Look at the Uninsured Marketplace Eligible Population Following the American Rescue Plan Act*, Kaiser Family Foundation (May 27, 2021), <https://www.kff.org/private-insurance/issue-brief/a-closer-look-at-the-uninsured-marketplace-eligible-population-following-the-american-rescue-plan-act/>.

²⁷ U.S. Dept. of Health & Human Srvs., Ctrs. for Medicare & Medicaid Srvs., U.S. Dept. of Treasury, HHS Notice of Benefit and Payment Parameters for 2022; *Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations*, 86 Fed. Reg., 6138, 6176 (Jan. 19, 2021), codified at 45 C.F.R. § 155.221(j).

²⁸ 86 Fed. Reg. 35167, citing Tara Straw, “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, CBPP (Mar. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>; 42 U.S.C. § 1396w-3 and 42 C.F.R. § 435.1200.

²⁹ Leukemia and Lymphoma Society, et al., *Under-Covered: How “Insurance-Like” Products Are Leaving Patients Exposed* (Mar. 25, 2021), https://www.lls.org/sites/default/files/National/undercovered_report.pdf.



Medicaid enrollment, the direct enrollment exchanges could significantly hinder efforts to ensure that people with low incomes and other underserved groups access affordable health coverage. We support repealing this provision.

Navigator Program Standards - § 155.210

The UPP Rule would reinstate previous requirements for Navigators to assist consumers in certain post-enrollment activities. In particular, Navigators would be required to help consumers:

- file appeals on Exchange eligibility determinations;
- understand basic concepts and rights associated with health coverage (such as explaining complex terms like deductible or coinsurance or helping them navigate drug formularies and provider networks);
- apply for an exemption to maintaining minimum essential coverage from the exchange;
- help consumers reconcile APTCs; and
- find assistance with tax filing.³⁰

The 2020 Notice of Benefit and Payment Parameters (NBPP) made these activities optional for Navigators and we strongly support the CMS's proposal to make these activities mandatory once again.³¹

The ACA created the Navigator program to provide outreach, assistance and education to consumers seeking health insurance through the ACA Marketplaces. Navigators are trained to provide free, unbiased, and comprehensive information about health coverage. Evidence has shown that consumers find the process of searching for and keeping health insurance overwhelming and highly value the assistance they receive from Navigators.³²

Evidence also shows that millions of people find the process of applying for and using health insurance overwhelming.³³ Many lack basic health insurance literacy. Evidence shows that Navigators can help demystify the complexity of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including Black, Indigenous, and other People of Color (BIPOC).³⁴ Given this, it

³⁰ 86 Fed. Reg. 35156, 35163-65.

³¹ 84 Fed. Reg. 17454, 17555.

³² Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, Kaiser Family Foundation (Aug. 7, 2020), <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-rief/>.

³³ *Id.*

³⁴ Jean Edward et al., *Availability of Health Insurance Literacy Resources Fails to Meet Consumer Needs in Rural, Appalachian Communities: Implications for State Medicaid Waivers*, 37 J. RURAL



is vital that Navigators be required not only to help consumers enroll in health coverage, but also be available to assist with post-enrollment activities.

Despite the vital role Navigators play, the past four years have seen dramatic cuts to the program. Between 2016 and 2020, program funding was slashed by eighty-four percent and the number of grantees cut in half.³⁵ It left at least one FFM state without any navigators and left large regional gaps in other states.³⁶ Millions of people looking for assistance with enrollment reported being unable to find help. Several states also reported that funding cuts limited outreach to rural communities and to Black and Latinx populations.³⁷ We welcome HHS's recent decision to increase Navigator funding to \$80 million for the 2022 plan year and recognize how important ongoing investments in funding and training for Navigators will be in rebuilding the program.³⁸

Finally, while we support the proposal to require Navigators to engage in post-enrollment activities, we are concerned that CMS did not propose to restore the requirements to have at least two in-person Navigator organizations in each state and to ensure that at least one of those organizations was a trusted community nonprofit. This requirement was eliminated in the 2019 NBPP.³⁹ Face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of applying, selecting a plan, resolving data matching inconsistencies, and assisting with appeals. Community entities with a physical presence will better know their communities and be better able to serve them because they likely interact with the target populations on an ongoing basis and are able to build relationships that transcend the application process.

HEALTH 526, 531-3 (June 25, 2020), <https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12485>; Victor G. Villagram, et al., *Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference*, 25 Am. J. Managed Care (Mar. 7, 2019), <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

³⁵ Katie Keith, *Marketplace Enrollment Tops 12 Million For 2021; Largest-Ever Funding For Navigators*, Health Affairs Blog (Apr. 22, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210422.65513/full/>.

³⁶ Karen Pollitz and Jennifer Tolbert, *Data Note: Limited Navigator Funding for Federal Marketplace States*, Kaiser Family Foundation (Oct. 13, 2020), <https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>.

³⁷ Olivia Hoppe and JoAnn Volk, *Affordable Care Act Navigators: Unexpected Success During 2018 Enrollment Season Shouldn't Obscure Challenges Ahead*, Georgetown University Health Policy Institute, Center on Health Insurance Reforms (Jan. 12, 2018).

³⁸ Ctrs. for Medicare & Medicaid Svcs., *CMS Announces \$80 Million Funding Opportunity Available for Navigators in States with a Federally-Facilitated Marketplace* (June 4, 2021), <https://www.cms.gov/newsroom/press-releases/cms-announces-80-million-funding-opportunity-available-navigators-states-federally-facilitated-0>.

³⁹ 83 Fed. Reg. 16930.



In-person assistance is especially critical in rural and underserved communities where people may not have reliable access to a computer or telephone. Consumer-focused nonprofits are often best positioned to serve as Navigator entities because they are often well-established trusted entities in their local community. They are uniquely positioned to provide outreach to high-need communities in their area. We strongly suggest CMS consider reinstating the requirements to have at least two in-person Navigator entities in every state and to ensure that at least one of those entities is a consumer-facing nonprofit.

User Fee Rates for the 2022 Benefit Year - § 156.50

In the UPP Rule, CMS proposes a modest increase to user fees - 2.75% for the FFM, up from 2.2%; and 2.25% for State Based Marketplaces using the federal platform (SBM-FP), up from 1.75%. The Marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. Under the previous administration, CMS slashed user fees and virtually ceased marketing and outreach and slashed funding for Navigators, core marketplace functions funded by user fees. We recommend CMS should *increase* the user fee to 3.5% (the level in effect prior to 2020) to restore outreach and enrollment assistance programs and to fund continued improvements to HealthCare.gov.

User fees are essential to operate the Marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. These include enhancing the consumer experience through improvements to the application and HealthCare.gov, as well as addressing other behind-the-scenes issues. We believe CMS should increase user fees and make much needed fixes and enhancements to Marketplace enrollment. If it does not do this via the UPP, we urge HHS to consider including a higher fee in later Notice of Benefit and Payment Parameter rulemakings.

Network Adequacy - § 156.230

CMS requests comments and input regarding how the federal government should approach network adequacy reviews in light of the court's decision in *City of Columbus v. Cochran*, 2021 WL 825973 (D. Md. Mar. 4, 2021).⁴⁰ We look forward to engaging with the administration on establishing, monitoring, and enforcement strong network adequacy standards. These should also include whether the provider network is sufficient to deliver culturally competent and anti-biased care and is fully accessible to persons with disabilities.

⁴⁰ 86 Fed. Reg. 35175.



CMS's network adequacy review by states and CMS should include an audit a sample of state reviews of network adequacy, and audit in response to red flags or consumer complaints. CMS should also review formulary adequacy. One enforcement tool for states and the federal government would be to review currently reported transparency data on the number of out-of-network claims denials and assess plans with high numbers of out-of-network denials for their size. This could be strengthened by requiring data on the total number of out-of-network claims submitted, and computing a denial rate. High rates of denials should prompt further review. We think this is especially important for certain types of out-of-network claims - such as mental health - as indicators of the types of care for which networks must be strengthened.

We urge CMS to require evidence that plan networks provide enrollees with sufficient access to providers of all reproductive health services that are covered, in accordance with federal and state policies, as well as to LGBTQ+-inclusive care. In fifty-two geographic regions around the country, the sole providers of acute care are facilities operated by religiously-affiliated health systems that do not allow contraceptive services, sterilizations, abortions, infertility treatments or some types of gender-affirming care.⁴¹ Particularly in those regions, it is important that plan networks include access to alternative providers of such care. In other regions, narrow plan networks could also inhibit enrollees' access to all covered services, should the networks not include alternative providers of care.

Further, states and CMS should conduct some direct tests of provider availability, discussed in the 2014 HHS Office of the Inspector General report highlighting the importance of direct testing of Medicaid provider networks.⁴²

We look forward to providing further comments on network adequacy standards, monitoring, and enforcement in future rulemaking.

Abortion “Double Billing” Rule—§156.280(e)(2)

NHeLP fully supports the proposal to completely repeal the 2019 changes to the double billing regulation at 45 C.F.R. § 156.280(e)(2). This regulation was not implemented due to pending litigation and the COVID-19 pandemic. If it had been implemented, it would have required qualified health plan (QHP) issuers to send a separate premium bill for abortion services to consumers and instruct consumers to pay a premium for abortion services in a separate transaction.

⁴¹ Tess Solomon, et al., *Bigger and Better: The Growth of Community Health Systems*, Community Catalyst (2020), <https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf>.

⁴² U.S. Dep't Health & Human Servs. Off. of the Inspector Gen. (OIG), *State Standards for Access to Care in Medicaid Managed Care*, No. 09-25-2014, (Sept. 29, 2014), <https://oig.hhs.gov/oei/reports/oei-02-11-00320.asp>.



We oppose this “double billing” regulation because it would have:

- undermined access to abortion, with devastating impact;
- caused confusion resulting in gaps in coverage and reduced access to abortion and health care generally;
- conflicted with Congress’ intent to allow abortion coverage in the ACA Marketplaces; and
- diminished state flexibility, conflicting with current state mandates to cover abortion and placing issuers in those states in a challenging position.

We also support codifying the proposal set forth in the preamble of the 2016 Payment Notice, offering QHP issuers flexibility to select a method that complies with the segregation requirement in § 1303 of the ACA. Repealing the changes to § 156.280 and offering flexibility to QHP issuers would align with the intent of the ACA, prevent consumer confusion, lessen the burden to QHPs, and ensure that consumers have the comprehensive health care plan that meets their needs.

1. *The double billing regulation would have undermined access to abortion, with devastating impact*

Abortion is a common and safe medical intervention. One out of four women in the United States will have an abortion by the age of forty-five.⁴³ Abortion is legal and a constitutionally protected form of medical care in the United States. Yet existing federal restrictions on insurance coverage, coupled with increasing federal and state attacks on access to abortion care, often render the constitutional right meaningless. Already, many are denied abortion coverage because of how much they earn, where they live, or how they are insured. For many, coverage for abortion care means the difference between getting the health care they need when they need it and being denied that care.

⁴³ See Rachel K. Jones and Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, 12 AM J. PUB. HEALTH 107 (Dec. 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5678377/>; See also, Nat’l Acad. of Sci., Eng’g & Med., *The Safety and Quality of Abortion Care in the United States*, <http://www.nationalacademies.org/hmd/Reports/2018/the-safety-and-quality-of-abortioncare-in-the-united-states.aspx> (Mar. 16, 2018) (finding that abortion in all forms is a safe and effective form of health care). NHeLP’s comments occasionally use the terms “women” or “woman” as well as other gendered language where the research data or laws cited uses those specific terms. We recognize that people of all genders, gender identities, and expressions require access to abortion and have tried to otherwise limit our use of gendered language where possible.



Half of abortion patients are low income individuals and many are seeking this care precisely because they experience economic hardships.⁴⁴ In a pernicious, cruel cycle, those same individuals must make difficult arrangements to raise funds to pay out-of-pocket for their abortions. The time that it takes to raise funds for abortion care often results in delays, which in turn can increase the cost of care. In a 2014 study, the average costs to patients for first-trimester abortion care was \$461, and anywhere from \$860 to \$1,874 for second-trimester abortion care.⁴⁵

Recent studies have confirmed that the cost of an abortion is a catastrophic expenditure for most people in the United States.⁴⁶ Delays can result in complete denial of abortion care, which can have long-term, devastating effects on pregnant people and their families' economic future. When forced to carry a pregnancy to term, a woman had almost a four-fold increase in the likelihood of living below the FPL and a higher chance of lacking the financial resources to pay for necessities.⁴⁷ Women who are denied abortion care are more likely to be the sole caretakers of their children in comparison to women who are able to receive the abortion care they needed.⁴⁸ This further demonstrates that pregnant individuals are making health care decisions that are best for themselves and their families. The double billing regulation could have well exposed many individuals and families to untenable economic circumstances.

Restrictions to abortion coverage particularly harm BIPOC as well as Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Gender Nonconforming (LGBTQI-GNC) individuals who disproportionately struggle with poverty.⁴⁹ BIPOC communities are overly represented in the abortion population – twenty-eight percent are Black and twenty-five percent are Latinx while they represent thirteen percent and eighteen percent of the U.S.

⁴⁴ See Rachel K. Jones and Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States*, 12 AM J. PUB. HEALTH 107 (Dec. 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5678377>.

⁴⁵ See All Above All and Ibis Reproductive Health, *The Impact of Out-of-Pocket Costs on Abortion Care Access* (Sept. 2016), [hereinafter *Impact of Out-Of-Pocket Costs on Abortion Care*], <https://www.ibisreproductivehealth.org/sites/default/files/files/publications/Brief%20OutOfPocket%20Impact.pdf>.

⁴⁶ See Carmela Zuniga et al., *Abortion as a Catastrophic Health Expenditure in the United States*, 30 WOMEN'S HEALTH ISSUES 6, 416-425 (Aug. 12, 2020).

⁴⁷ Advancing New Standards in Reproductive Health, *Issue Brief: Socioeconomic Outcomes of the Women Who Receive and Women Who are Denied Wanted Abortions* (Aug. 2018), https://www.ansirh.org/sites/default/files/publications/files/turnaway_socioeconomic_outcomes_issue_brief_8-20-2018.pdf.

⁴⁸ *Id.*

⁴⁹ See Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, 20 GUTTMACHER POL'Y REV. 39, 40 (2017), <https://www.guttmacher.org/qpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health>.



population respectively.⁵⁰ Neither are abortions limited to cisgender heterosexual women. The Guttmacher Institute found that in 2017, approximately 462 to 530 transgender and non-binary individuals obtained abortions.⁵¹ People with disabilities also face barriers to reproductive and sexual health care, including abortion, which adds to the stigma of disability and sexuality for this population.⁵²

Individuals who are denied abortion access have been found to endure adverse physical and mental health consequences. According to a longitudinal study, individuals denied abortions are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy, more likely to remain in relationships where interpersonal violence is present, and more likely to suffer anxiety in the short term after being denied an abortion.⁵³

2. *The double billing regulation would have caused confusion resulting in gaps in coverage for individuals, reducing access to abortion and health care generally*

The complicated double billing rule would have led to widespread enrollee confusion and anxiety, particularly in the uncertainty produced by a deadly pandemic. If implemented, the double billing regulation would have lessened consumers' ability to make informed decisions about the plans that met their needs. Worse, individuals would have experienced delays in coverage as they attempted to understand how to make their premium payments, or eventually lose coverage.

Consumers would have been confused to receive two separate bills from the same plan. They would have had to send two separate checks or submit two separate online transactions. Consumers would have struggled with navigating these changes; most would not have had the resources or time to follow up with QHPs in order to understand this complicated process and some would not have paid both premiums. Many would have believed that a separate bill was

⁵⁰ See Guttmacher Inst., *Abortion Demographics*, <https://www.guttmacher.org/united-states/abortion/demographics> (last visited July 12, 2021). See also, U.S. Census, *Quick Facts*, <https://www.census.gov/quickfacts/fact/table/US/PST045219> (last visited July 12, 2021).

⁵¹ See Rachel K. Jones and Elizabeth Witner, Guttmacher Inst., *Transgender abortion patients and the provision of transgender-specific care at non-hospital facilities that provide abortions* (Jan. 2020), <https://www.guttmacher.org/article/2020/01/transgender-abortion-patients-and-provision-transgender-specific-care-non-hospital>.

⁵² See Ipas, *Access for Everybody: Disability Inclusion in Abortion and Contraception Care* (2018), <https://www.ipas.org/wp-content/uploads/2020/07/AEDIOE18-AccessForEveryone.pdf>.

⁵³ See Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. HEALTH 407 (Feb. 2018), <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247>.



a scam, an error by the issuer, or a charge for coverage that they did not request. Consequently, enrollees and shoppers would experience delays in coverage.

The impact would have been worse for individuals who already face barriers in navigating health insurance, particularly individuals with low literacy and communities of color and Limited English Proficient (LEP) speakers. According to an *Accenture* report, more than half of U.S. consumers have low health care system literacy, with only sixteen percent qualifying as experts.⁵⁴ Even when accounting for education, racial disparities exist in health insurance literacy. In one study of QHP enrollees in Connecticut, Blacks and Latinx respondents with the same education level as whites scored lower on a survey question about the meaning of health insurance terms or how to best use their insurance. Black and Latinx individuals with a Bachelor's degree answered fifty percent of the questions correctly while whites with the same degree answered seventy-four percent of these questions correctly.⁵⁵

Limited English Proficient speakers face increased challenges in understanding health insurance. In the same study mentioned above, enrollees who chose to take the survey in English scored significantly higher than individuals who chose to take the survey in Spanish.⁵⁶ The double billing regulation did not address how LEP individuals might overcome barriers in complying with the proposed changes, nor did it propose any requirements or guidelines for how issuers should educate, inform, and conduct outreach to consumers regarding these changes in billing and payment. Thus the regulation would have harmed not only LEP individuals, but also immigrants, individuals with low literacy and educational levels, and those living with visual disabilities and/or impairments.

QHP enrollees would have also experienced financial burdens as a result of the double billing regulation. The projected burden to all issuers, states, state Marketplaces performing premium billing and payment processing, the FFMs, and consumers would have totaled \$546.1 million in 2020 alone.⁵⁷ It was also anticipated that these costs would have been passed on to consumers in the form of higher premiums.⁵⁸ Furthermore, these figures do not account for the added costs it takes for consumers to learn how to comply with the double billing regulation.

⁵⁴ Accenture, *The Hidden Cost of Healthcare System Complexity* (2018),

https://www.accenture.com/_acnmedia/pdf-104/accenture-health-hidden-cost-of-healthcare-system-complexity.pdf.

⁵⁵ See Victor G. Villagra et al., *Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference*, 25 AM. J. MANAGED CARE 3 (Mar. 2019), <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

⁵⁶ *Id.*

⁵⁷ 45 C.F.R. § 156.280.

⁵⁸ See AHIP, Comment Letter on HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P) (Dec. 22, 2014); Anthem, Comment Letter on HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P) (Dec. 22, 2014).



In sum, the double billing regulation would have harmed those who already struggle to navigate the health care system—including BIPOC, low literacy people, people with disabilities and limited English proficiency—who are also more likely to need health care. The regulation would have added anxiety and heightened barriers to health care access.

3. *The double billing regulation conflicted with Congress' intent to allow abortion coverage in the ACA Marketplaces*

Although § 1303 of the ACA unfairly segregates abortion from other health care coverage and imposes additional burdens on issuers that offer QHPs covering abortion services, Congress always intended § 1303 to retain availability of abortion coverage, including allowing states to require abortion coverage.⁵⁹ Congress rejected amendments aimed at more stringent restrictions or prohibitions of abortion coverage during the health care reform debate and negotiations. For instance, the Senate refused to adopt the Stupak-Pitts Amendment, which would have banned coverage of abortion in the marketplaces, as well as barred federal subsidies for any QHP that covered abortion in cases other than rape, incest, or risk to the pregnant individual's life.⁶⁰ In addition, the Senate rejected the Nelson-Hatch Amendment by a vote of fifty-four to forty-five. That amendment had a similar goal to ban coverage of abortion services in the marketplaces.⁶¹ Congress ultimately adopted the Nelson Amendment to replace all other proposed amendments, permitting insurers to cover abortions so long as they comply with the provisions of § 1303.⁶²

Section 1303 explicitly required issuers to segregate funds and accounts for abortion coverage; it did not pass on that burden to consumers or add more requirements for QHPs. As

⁵⁹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010) (collectively the "Affordable Care Act (ACA)").

⁶⁰ See Amendment to H.R. 3962, 111th Cong. (2009) (offered by Rep. Stupak and Rep. Pitts), 155 CONG. REC. H 12,921 (Nov. 7, 2009), <http://documents.nytimes.com/thestupak-amendment>.

⁶¹ See, e.g., 155 CONG. REC. S 12,665 (2009) (statement of Sen. Patty Murray): "All Americans should be allowed to choose a plan that allows for coverage of any legal health care service, no matter their income, and that, by the way, includes women. But if this amendment were to pass, it would be the first time that Federal law would restrict what individual private dollars can pay for in the private health insurance marketplace."

<https://www.congress.gov/congressionalrecord/2009/12/08#daily-digest-senate>; id. at S. 12,666 (statement of Sen. Ben Cardin): "The Nelson-Hatch amendment would go beyond that. It would restrict a woman's ability to use her own funds for coverage to pay for abortions. It blocks a woman from using her personal funds to purchase insurance plans with abortion coverage. If enacted, for the first time in Federal law, this amendment would restrict what individual private dollars can pay for in the private insurance marketplace."

⁶² 42 U.S.C. § 18023(b)(2)(A).



such, we also support the proposal to change the section heading of § 156.280 to “Segregation of funds for abortion services,” to better align with the intention of § 1303 of the ACA. The double billing regulation undermined the intent of the ACA because it would have created onerous administrative burdens for issuers that cover abortions in their QHPs. The UPP Rule resolves that concern.

4. *The double billing regulation would have diminished state flexibility, conflicting with current state mandates to cover abortion and placing issuers in those states in a challenging position*

Section 1303(c)(1) states that the ACA “does not preempt or have any other effect on state laws regarding the requirement of (or prohibition of), any coverage, funding, or procedural requirements on abortions.”⁶³ Hence, no federal rules should interfere with states’ decisions and mechanisms regarding coverage of abortion services. Recognizing that reproductive health care is a critical part of a person’s wellbeing, some states require abortion coverage in most of their plans, just like any other health service.⁶⁴ For example, California’s Constitution and its Knox-Keene Health Care Service Plan Act of 1975 require that abortions must not be treated differently from other health care services. As a result, most health plans in the state, including QHPs, must cover abortion services.⁶⁵

The double billing regulation combined with the already onerous regulatory requirements of § 1303 would have interfered with a state’s requirement to offer abortion coverage in their plans. Back in 2019, HHS threatened to enforce the double billing regulation if states opt not to follow it, seriously overriding states’ authority over issuers that operate in their states.⁶⁶ The double billing regulation would have disrupted the nature of collaboration and partnership that the ACA meant to create between the states and the federal government. At best, this new relationship will be confusing, and at worst, it would have been detrimental to health care coverage across the country.

We support the complete repeal of the 2019 changes to § 156.280. The double billing regulation went far beyond the underlying statute, imposed onerous and unnecessary burdens on both issuers and consumers that would have resulted in the loss of insurance coverage and reduced access to comprehensive health care, including reproductive and sexual health services.

⁶³ 42 U.S.C. § 18023; 45 CFR § 156.280.

⁶⁴ Guttmacher Inst., *Regulating Insurance Coverage of Abortion: As of July 1, 2020*, <https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion#>.

⁶⁵ See *Committee to Defend Reprod. Rights v. Myers*, 625 P.2d 779 (Cal. 1981); Cal. Health & Safety Code § 1340.

⁶⁶ 45 C.F.R. § 156.280.



Restoration of § 1332 Waiver Guardrails - §§ 33.108 - 33.132

The UPP Rule would reverse attempts to undermine important guardrails governing § 1332 waivers. The ACA's § 1332 guardrails require that waivers cover at least as many people, with coverage at least as comprehensive and affordable as would be the case without the waiver, without increasing the federal deficit.⁶⁷ The Trump administration attempted to undercut these statutory requirements by issuing § 1332 guidance in 2018.⁶⁸ It then issued a concept paper encouraging states to submit waiver proposals that would weaken protections for people with pre-existing conditions, cut financial assistance for consumers with low incomes and/or older people, and/or increase out-of-pocket costs, implying that such waivers might be approvable under the new guidance.⁶⁹ In the last days of the Trump administration, CMS finalized regulations codifying provisions of the 2018 guidance.⁷⁰ These policies weakening critical § 1332 requirements are harmful and unlawful. We strongly support their repeal.

The ACA requires that § 1332 waivers provide coverage that is at least as comprehensive as plans offered through the Marketplaces, including EHB coverage standards.⁷¹ However, the January rule reinterpreted the plain language of the statute to allow states to provide only “access to” comprehensive coverage, including STLD plans.⁷²

We support the UPP Rule's return to a more reasonable interpretation of the statute's language and intent and one that will better support people's access to high-quality coverage. The proposal would be strengthened by amplifying the preamble's language in the rule text to be clear that a § 1332 waiver cannot decrease the number of people with coverage that satisfies EHB requirements, the number of people with coverage of any particular category of EHB, or the number of individuals with coverage that includes the services covered under the

⁶⁷ 42 U.S.C. § 18052(b)(1).

⁶⁸ U.S. Dept. of Health & Human Svcs., U.S. Dept. of Treasury, *State Relief and Empowerment Waivers*, 83 Fed. Reg. 53,575 – 53,584 (Oct. 24, 2018), <https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf>.

⁶⁹ Ctrs. for Medicare & Medicaid Services, *Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper* (Nov. 29, 2018), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>. See also Joel McElvain, *The Administration's Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act's Statutory Guardrails*, YALE J. ON REG. (Dec. 11, 2018), <https://www.yalejreg.com/nc/the-administrations-recent-guidance-on-state-innovation-waivers-under-the-affordable-care-act-likely-violates-the-acts-statutory-guardrails-by-joel-mcelvain/>.

⁷⁰ U.S. Dept. of Health & Human Svcs., Ctrs. for Medicare & Medicaid Svcs., U.S. Dept. of Treasury, HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 86 Fed. Reg., 6138 - 6178 (Jan. 19, 2021), <https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-01175.pdf>.

⁷¹ 42 U.S.C. § 18052(b)(1)(A).

⁷² 31 C.F.R. § 33.108(f)(3)(iv)(A).



state’s Medicaid or CHIP programs. The rule should reaffirm that these criteria must be met in each year of the waiver.

Section 1332 of the ACA requires that the state plan “will provide coverage and cost-sharing protections against excessive out-of-pocket spending” that are at least as affordable as other coverage under Title I of the ACA.⁷³ As with the comprehensiveness guardrail, the current rules only require providing “access to” such coverage and so create a pathway for lower-cost substandard coverage to satisfy the regulatory requirements. But while this coverage might have lower premiums, consumers can ultimately pay more based on coverage exclusions and denials that can vastly increase out-of-pocket costs.

We support the proposed rule and further ask that it codify the language in the preamble clarifying that affordability refers to consumers’ ability to pay health care costs “relative to their income ... measured by comparing each individual’s expected out-of-pocket spending for health coverage and services to their incomes.” The preamble continues to say that the Departments’ affordability assessment will take into account the effects of the waiver on vulnerable and underserved groups who have been historically marginalized, and that waivers that make coverage less affordable for those groups are unlikely to be approved. This is important language because various subgroups of people, such as lower-income people, people of color, older adults, individuals with significant health needs, and others may face particular affordability challenges that may not be recognized if affordability is only looked at in the aggregate.

Section 1332 also requires states to “provide coverage to at least a comparable number of residents” as Title I of the ACA.⁷⁴ The current regulation contradicts the statutory language by explicitly counting STLD plans as coverage for this purpose, even though those plans fail to meet EHB and other requirements of Title I.⁷⁵ An overriding goal of the ACA was to increase coverage rates, and § 1332 was explicitly written to preserve this objective and include other key protections such as EHB and affordability. Coverage must be provided to a comparable number of state residents, which includes, as noted in the preamble, changes in Medicaid enrollment and should consider the effects on different vulnerable sub-populations instead of only looking globally at coverage numbers. Those provisions should be codified, as should the requirement that “coverage” must be minimum essential coverage.

The 2018 guidance and discussion paper and January 2021 regulation invited states to propose waiver plans that would weaken or eliminate protections for the very groups the ACA was meant to help. Only one, Georgia, submitted and won approval for such a waiver. We strongly support repealing these provisions which could lead states to attempt legally dubious

⁷³ 42 U.S.C. § 18052(b)(1)(B).

⁷⁴ 42 U.S.C. § 18052(b)(1)(C).

⁷⁵ 31 C.F.R. § 33.108(f)(3)(iv)(C).



waivers that would leave more people uninsured, saddle low-income families with higher costs, reduce protections for people with high-cost health needs, and unravel insurance markets in which people with pre-existing conditions can obtain affordable, comprehensive coverage.

Modification from the normal public notice requirements during an emergent situation - § 155.1318

The UPP Rule proposes to allow states to avoid adequate public notice and opportunity to comment for § 1332 waivers in certain “emergent situations” such as natural disasters, public health emergencies, and other situations.⁷⁶ We disagree with this proposal. Requirements for § 1332 public notice and opportunity for a “meaningful level of public input” are statutory, designed to ensure public input and transparency in state efforts to transform their health delivery systems.⁷⁷ Section 1332 waivers are designed to implement health system innovations, not to respond to disasters and other emergencies. Congress has provided other authority to respond to natural disasters and other emergencies.⁷⁸ We urge CMS to reconsider this proposal.

Conclusion

We have included citations and direct links to research and other materials. We request that the full text of material cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If CMS is not planning to consider these citations part of the record as we have requested, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to comment on this important issue. Please feel free to contact me at (202) 289-7661 or turner@healthlaw.org if you have questions.

⁷⁶ 86 Fed. Reg. 35215.

⁷⁷ 42 U.S.C. § 18052(a)(4)(B)(iii).

⁷⁸ See, e.g., Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), Pub. L. No. 100-707, 102 Stat. 4689 (1988) (codified as amended at 42 U.S.C. §§ 5121–5208); Social Security Act of 1935, Pub. L. No. 74-271, § 1135, 49 Stat. 620, 736–739 (codified as amended at 42 U.S.C. § 1320b–5); Public Health Service Act, Pub. L. No. 78–410, § 319, 58 Stat. 682 (1944) (codified as amended at 42 U.S.C. § 247d).



Yours truly,

A handwritten signature in black ink, appearing to read 'W. Turner', followed by a long horizontal flourish.

Wayne Turner
Senior Attorney

