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THE VOICE FOR HEALTH CARE CONSUMERS

July 28, 2021

The Honorable 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: Comments on the Proposed Rule Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule, CMS-9906-P, RIN 0938-AU60

Submitted via Regulations.gov

Dear Administrator Brooks-LaSure:

I am writing on behalf of Families USA, a national, non-partisan voice for health care consumers, dedicated to achieving high-quality, affordable health care and improved health for all, to provide comments on the **Proposed Rule Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond.** We appreciate the opportunity to share feedback on the proposed rule, which proposes standards for issuers, Exchanges, and Navigators**.**

The comments that follow are divided into three parts: first we provide feedback on the proposed payment parameters, largely supporting the Administration's proposed changes. Second, we comment on proposed modifications to 1332 waivers, sharing our deep concern that the Administration is proposing to maintain outdated statutory understandings that will close off progressive policy ideas for state Marketplaces. Finally, we lay out several critical areas for future CCIIO rulemaking.

Our specific comments are below:

I. Proposed Payment Parameters

Reinstatement of Navigator Duties

Families USA fully supports reinstating the policy (155.210) that allows navigators to help consumers navigate the health care system even after they have been successfully enrolled in coverage. This policy was withdrawn under Trump administration regulations. The policy previously included allowing navigators to address consumer issues that arise in the marketplace concerning exchange eligibility and appeals, use of coverage, and premium tax credits. In 2015, when previous rules and funding allowed for post-enrollment assistance, 79% of navigators and enrollment assisters reported that they helped with post-enrollment issues.[1] Post-enrollment assistance can entail helping consumers read and understand notices, gathering relevant documents, finding appropriate providers and scheduling initial appointments, understanding bills

[1]K. Pollitz, J. Tolbert and R. Ma, Kaiser Family Foundation 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers, https://files.kff.org/attachment/topline-2015-survey-of-health-insurance-marketplace-assister-programs-and-brokers, August 2015.

and cost-sharing requirements, reporting changes relevant to the marketplace, and placing a series of calls to relevant plan, provider, or marketplace personnel to clarify and resolve an issue. Navigators have performed these duties successfully in past years.

If CMS does restore the post-enrollment function, CMS should increase grants to navigators in year-2 when navigators will again take on post enrollment duties.

Community-based navigators, who have an in-person presence in the communities they serve, and established relationships with enrollees, can be particularly helpful in providing post-enrollment assistance.[2] **CMS should reinstate requirements that there be at least one community-based nonprofit navigator in each state and service area, and that navigators have a duty to help all applicants, including through the process of application completion**.

Removal of the Exchange Direct Enrollment Option

We wholeheartedly support removal of the Exchange Direct Enrollment option (155.221(j)). Exchanges provide a valuable function as a place to view comprehensive health insurance that meets federal standards, obtain advance premium tax credits and cost-sharing reductions, and as a pathway to Medicaid and CHIP for those that are eligible for those benefits. As we commented previously, enhanced direct enrollment would have confused consumers, leading them to use entities that did not display all available plans and that may not have provided "no wrong door" seamless applications to Medicaid and CHIP. We agree that implementing direct enrollment at this time would have added complexity to marketplaces and detracted from implementation of the American Rescue Plan and future reforms.

Lengthening Open Enrollment Period (OEP) through at least January 31, 2022.

As proposed (155.410(e)), we support lengthening the open enrollment period. As noted, this will give consumers time to change plans if they find that their premiums have changed in the new year. However, **we recommend lengthening that period to the end of January**, giving people more time to schedule appointments with navigators and enrollment assisters after the holidays, and ensuring that people have time to see and understand notices about their new premiums. California legislation (AB 1309) permanently extended its marketplace enrollment period through January 31 beginning in 2020, one of several measures that led to increased enrollment. California plans were still able to effectuate enrollment for February 1. In 2021, many other state based marketplaces kept enrollment open beyond January 15 as well as providing additional special enrollment periods during the pandemic.[3]

An additional reason to extend open enrollment until at least January 31st relates to people losing Medicaid and CHIP eligibility. In 2022, we anticipate that a number of people who had been on Medicaid will need to move to marketplace coverage as the Medicaid emergency Maintenance of Effort ends. **Though they will be eligible for a special enrollment period (SEP), we urge CMS to keep the enrollment process as simple as possible, minimize documentation requirements, and afford them every opportunity to enroll in marketplace coverage**. Maintaining open enrollment in the marketplace through at least the end of January will facilitate that transition.

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[2] Phil Gallewitz, "Short on Funding, Navigators Switch Tactics," Kaiser Health News, https://khn.org/news/short-on-federal-funding-obamacare-enrollment-navigators-switch-tactics/, November 30, 2018;

[3] https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files.

Changing Default Renewal Regulations

We urge the Department to revise regulations governing renewal of marketplace enrollees' coverage during the OEP. Currently, if a consumer does not affirmatively select a plan, the consumer's former plan selection remains in effect, even if alternative plan options have changed substantially. A better structure would allow for limited auto-renewal into highly similar but lower-cost plans. If the current auto-renewal policy applies during the coming OEP, numerous low-income consumers are likely to suffer harm.

A recent analysis by Anderson, Rasmussen, and Drake[4] found that 5.8% of California's marketplace enrollees whose coverage stands to be passively renewed would find themselves paying approximately $100 extra per month in premiums for a plan with deductibles $2,000 higher than what they would have received if the marketplace default was to move them to lower-costing plans. Nearly all (more than 98%) of affected consumers have low household incomes.

Instead of the current default which keeps consumers enrolled in their current plan, the "smart" default renewal rule urged by Anderson and colleagues provides a process to assess whether there is a highly similar but better plan available and moves consumers only between plans with the same insurer, product design, and provider network. Consumers are shifted only when the new plan is at a more generous metal level (counting CSR silver-tier variants as comprising distinct metal levels, with 87%-AV and 94%-AV variants classified as more generous than gold) and the net premium is equal to or less than the premium charged by the former plan. Such a rule could be implemented based on several facts known to the marketplace:[5]

- Each plan's 5-character HIOS ID, which identifies the insurance company;
- Provider network ID;
- Plan Type (HMO, PPO, EPO, POS);
- Metal Level; and
- The consumer's APTC amount.

The vast majority of consumers changing coverage would move from bronze or gold plans to 87%-AV or 94%-AV silver plans, while saving money on premiums (or spending no more on premiums).

We urge HHS to require this policy for all Marketplaces for the coming open enrollment period. It will be the first OEP in which American Rescue Plan APTC enhancements will be available. Selecting plans is difficult and people will often let their previous plan choices remain in effect even though plan choices will change dramatically, due if nothing else to increased APTCs. The adoption of the smart default option would ensure that people don't automatically continue in a plan that is clearly not the best choice.

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[4] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2782057

[5] See the Supplement by Anderson and colleagues: https://cdn.jamanetwork.com/ama/content_public/journal/jama-health-forum/938728/aoi210023supp1_prod_1626384495.45543.pdf?Expires=1629499946&Signature=BVKGcZuvNSLCz4DkWwOeUYG-A6BeEy70B~gs67h4-D4sRLhcKe0V2evNY2bzgEroJ3tHFOnNtVYEmvcarRvxI373k4muaMVUklGn6Pca7a65E0fe28a1NsOzkRJ4OWlGcF8FEra871-I-ZURr-JZD3ggRJsY-83zrrp092eYzu~y428S-TDuXsKXIB1B0bIyRIRPHKLHLZJghufpw2tBFouG9unuBAfQp5sx63ZtfogvgxtqT7C5EJeRWmerLLYE4GlKSAahQWH~pev~STTq0xsO754O9LkkNli0nTbb57MiLQqA7rcyWN6iGURLUtkyRQFEeoxg80g5uDo0liQBqw__&Key-Pair-Id=APKAIE5G5CRDK6RD3PGA

To be clear – this is a default option that would go into effect only if the consumer made no other choice. Both before and after that option is implemented, consumers should be given notice and an opportunity to reject the change and stay with their current plan.

Operationally, with some Marketplaces, it may be easier to implement such "smart" defaults if insurers rather than Marketplaces make those transfers. Such private-sector changes would need to be accompanied by the same opt-out chances and notice requirements that would otherwise apply to Marketplace actions.

Monthly special enrollment period (SEP) for people with incomes up to 150% of poverty

We support this (155.420(d)) proposal that CMS provide a recurring monthly enrollment opportunity for marketplace coverage for people with incomes up to 150% FPL. This policy change promotes enrollment and access to health care among an income group with high uninsurance rates, many of whom qualify for no cost health insurance through the marketplace. States such as Massachusetts, Minnesota, and New York have been able to achieve high enrollment rates for low-income residents, without signs of significant adverse selection, by maintaining year-round enrollment opportunities.[6] At low- and middle-income levels, families face the highest rates of job losses, even before the pandemic.[7] These families fluctuate between Medicaid eligibility, marketplace eligibility, and job-based coverage. Small changes in hours of work and wages can alter program eligibility and disrupt family budgets. Further, when the public health emergency ends, some households that received Medicaid under FFCRA's Maintenance of Effort provisions will need to instead move to marketplace coverage, a process that may require outreach, time, and assistance. We support giving such households every possible opportunity to enroll in coverage.

Parity

We support this (156.115(a)(3)) technical amendment that would clarify requirements to comply with the Mental Health Parity Addiction Act, including any amendments made to that law.

Repeal of separate billing regulation for abortion coverage

We fully support the proposal to repeal the separate billing regulation at 156.280(e)(2) and to codify QHP issuer flexibility to select a method of segregation of funds that meets requirements in 1303 of the ACA. Repealing the separate billing regulation is consistent with Congressional intent: In enacting the ACA, Congress segregated coverage for abortion services from other health care coverage and maintained Hyde Act provisions that federal funds not pay for abortion, but retained the availability of abortion as a potentially covered service and allowed states to require abortion coverage. The Senate refused to adopt the Stupak-Pitts Amendment, which would have banned coverage of abortion in the exchanges, as well as barring federal subsidies for any QHP that covered abortion in cases other than rape, incest, or risk to the

[6] Sarah Lueck, Broadening Marketplace Enrollment Periods Would Boost Access to Health Coverage, Center on Budget and Policy Priorities, April 19, 2021, https://www.cbpp.org/research/health/broadening-marketplace-enrollment-periods-would-boost-access-to-health-coverage.

[7] Gould and Kandra, Wages grew in 2020 because the bottom fell out of the low-wage labor market, Economic Policy Institute, February 24, 2021, https://www.epi.org/publication/state-of-working-america-wages-in-2020/

pregnant individual's life.[8] Likewise, the Senate rejected the Nelson-Hatch amendment that had a similar goal to ban coverage of abortion services in the marketplaces.[9]

The separate billing regulation – which were halted by multiple federal court challenges but would have required QHPs to send consumers separate bills for coverage of abortion serves and for coverage of other services - runs counter to this framework. It would be costly to administer.[10] The complexity of paying two separate bills would cause confusion for consumers, and likely cause many to lose coverage for abortions.

User fee recommendation

We support the proposal to increase marketplace user fees. User fees should be adequate to support key functions of the exchange, including upgrades to healthcare.gov, robust outreach, navigator grants (including sufficient funding to provide post-enrollment assistance and an in-person presence), creation and maintenance of a navigator portal that allows navigators to see the status of an applicant they are assisting, and funding to improve call center functions. We support increasing user fees to cover these functions.

However, we (and other commenters) do not have enough information to comment on what amount of user fees would adequately support these functions because the expenditure of marketplace user fees has been too opaque. **We request more transparency in the future regarding how revenues from marketplace user fees are administered, including how they are spent, what fees (if any) remain unspent, and major expenditure needs and plans in the coming year to, for example, upgrade technology, enhance navigator grants, or improve the call center.**

II. Modification of 1332 Waiver for State Innovation

Fiscal constraints preventing innovations that cover the uninsured

We urge a revision to the Department's interpretation of the federal deficit neutrality guardrail. Maintaining the current interpretation will preclude state innovation that has the potential to increase enrollment among people who qualify for financial assistance, since enrollment increases typically raise aggregate federal spending. The ACA's core policy objective is reducing the number of uninsured. The Department's interpretation of state innovation waivers means that such waivers are effectively forbidden when they promise to better achieve that core policy objective. A longstanding canon of statutory interpretation—including recent judicial rulings on Medicaid waivers—is that a law should be interpreted to promote rather than undermine the accomplishment of its core objectives.

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[8] *See* Amendment to H.R. 3962, 111th Cong. (2009) (offered by Rep. Stupak and Rep. Pitts), 155 CONG. REC. H12,921 (Nov. 7, 2009), http://documents.nytimes.com/thestupak-amendment.

[9] *See*, *e.g.*, 155 CONG. REC. S12,665 (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."

[10] 84 FR 71,698.

In other contexts, federal officials have construed waiver authority to permit increased enrollment of eligible people. For example, Medicaid waivers under section 1115 of the Social Security Act have long been subject to an administratively-imposed requirement of federal budget neutrality. Beginning with then-President Clinton's grant of a Medicaid 1115 waiver to permit the State of Tennessee to cover otherwise ineligible poor adults, CMS has permitted states to juxtapose waiver spending against baselines reflecting state implementation of alternative policies permitted without any waiver. A fixed quantity of federal dollars shifts from a policy the state could have implemented under the statute and instead is used to support the waiver. Federal budget neutrality is preserved under the waiver, relative to a baseline consisting of what the state could have done without a waiver. CMS has in recent years granted multiple Medicaid waivers with budget neutrality calculations referencing the 1902(a)(10)(A)(ii)(XX) state option to cover up to a state's entire non-elderly adult population under Medicaid. More generally, CMS has options to allow states to adopt progressive policy that clearly promotes statutory objectives. By maintaining the strict budget neutrality interpretation, the proposed rule makes it impossible for states to test innovations that have the potential to improve coverage for the uninsured. We now know that a growing list of states have good ideas for section 1332 waivers, and we also know that the Trump administration was ready to ignore both the 2015 guidance and the ACA's statutory language when it came to section 1332. We did not know either of these things in 2015. A narrow construction of section 1332 deficit neutrality requirements is an unnecessarily constricted legal reading deriving from a defensive political calculus from 2015 that was subsequently discredited on its own terms.

Comprehensiveness of coverage

We agree with the proposed changes in 31 CFR 33.108(F)(3)(IV)(A) AND 45 CFR 155.1308(F)(3)(IV)(A)) that would use essential health benefits and Medicaid coverage as a standard of comparison for comprehensiveness. The statute specifically requires that coverage under a waiver "be at least as comprehensive as the coverage defined in section 1302(b) and offered through Exchanges…." We understand that to mean that while the precise benefits under a waiver may differ from the essential health benefits benchmark, the overall package must be at least equally comprehensive. We agree that the regulations should echo the statutory language regarding coverage that is actually "provided" under the waiver, not just coverage that is available.

We also agree with guidance provided in the preamble that waiver proposals should consider the effect on comprehensiveness of coverage for residents of the state overall as well as on vulnerable populations.

Affordability

We agree with the proposed changes in (31 CFR 33.108(F)(3)(IV)(B) AND 45 CFR 155.1308(F)(3)(IV)(B)) that would require coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of Title I of the ACA.

The preamble notes that the three Departments with jurisdiction will evaluate whether people have large health care spending burdens relative to their incomes, and will examine the effects on various vulnerable groups, but the proposed regulation does not pick up this language. Since the statute includes increased assistance for people with modest incomes, we believe that the regulations should similarly require examination of the effect of a proposed waiver on the groups now eligible for the largest premium credits and cost sharing reductions.

Scope of coverage requirement

The proposed language at **31 CFR 33.108(F)(3)(IV)(C) AND 45 CFR 155.1308(F)(3)(IV)(C))** requires the Secretaries of the Departments with jurisdiction to determine that the State plan will provide coverage to a comparable number of state residents under the waiver as would have coverage absent the waiver. **This section should be clarified to indicate that the coverage it references is comprehensive coverage, meeting the standards set forth in (A): the waiver should provide comprehensive coverage to at least a comparable number of state residents.**

Modification of Normal Waiver Proposal Notice and Comment Period in Emergencies

We have concerns about the latitude that the proposed modification would provide under a vaguely defined "emergency."

We agree that the 1332 waiver process should be expedited in cases of natural disaster, public health emergency, or other sudden emergency threats to human lives – similar to authority that states have used well for people who rely on Medicaid under 1115 waivers. However, the proposed 1332 regulation refers also to "other emergent situations that threaten consumers' access to health insurance coverage, [and/or] consumers' access to health care." We are concerned about the vagueness of this section, particularly because it does not define "health insurance coverage" to be comprehensive and is thus subject to misuse.

The Medicaid 1115 emergency process includes more constraints. It applies only in cases of natural disaster, public health emergency, or other sudden emergency threats to human lives. The state must show that it acted in good faith, and in a diligent, timely, and prudent manner; the circumstances constitute an emergency and could not have been reasonably foreseen; and delay would undermine or compromise the purpose of the demonstration and be contrary to the interests of beneficiaries. **We recommend that the emergency 1332 process include similar language.**

We support the procedural requirement that states detail any justification for seeking emergency authority, and detail alternative meaningful public input processes.

Monitoring and compliance

Our earlier recommendation that ACA Section 1332 be construed to permit innovations that increase the number of people receiving health coverage has implications for the proposed regulation defining federal pass-through payments (31 CFR 33.120 & 45 CFR 155.1320). As noted above, states should receive the same flexibility under Section 1332 to define the baseline against which waiver spending is compared that states have long received with Medicaid waivers under Social Security Act Section 1115. In addition to determining the application of the federal deficit neutrality guardrail, this same approach needs to shape the calculation of federal pass-through payments. If the state's alternative baseline scenario would take advantage of statutory options to raise the amount of federal financial assistance for which an individual qualifies, that amount should be used to define federal pass-through payments under the waiver.

Waiver amendments

We support the proposed regulations at 31 CFR 33.130 and 45 CFR 155.1330 that delineate the process by which a state is permitted to submit an amendment to an approved section 1332 waiver, including a public comment process.

III. Issues for future rulemaking

Standardized Plans

Pursuant to the ruling in the *Columbus v Cochran*[i], CMS will require carriers to issue standardized plans in the future. CMS notes in the preamble that the timeline for plan and rate submission does not make it practical to do this for 2022. **We request that CMS move expeditiously to put standardized plans into place for 2023. These plans should:**

- Require pre-deductible coverage of some services, and provide for copayments instead of co-insurance. Deductibles pose a barrier to needed care and exacerbate health disparities.[11] Standardized plans should make it easier for consumers to afford and understand the likely costs for health care;
- Enable consumers to easily compare plans that all offer services at the same costs, based on differences in their provider networks, quality measures, and premiums;
- Be easy to identify on the healthcare.gov website.

CCIIO should examine state-based marketplace experience in determining its own standard plan designs. For instance, a quick review of these designs shows the following designs: California offers only standard plans, facilitating comparisons and quality shopping. Connecticut offers plans with no deductible for office visits, mammography, speech/physical/occupational therapy, diabetes equipment and supplies, and home health, and its plans provide a separate low deductible for drugs. Additionally, pediatric dental care is an embedded benefit and plans provide children's preventive dental care at no cost. In the District of Columbia, at the silver level, office visits, lab tests, generic drugs, urgent care, prenatal care, outpatient recovery services such as PT/OT, and child eye and dental services are pre-deductible. Massachusetts offers plans at the silver level that provide pre-deductible coverage for tier 1 and 2 drugs, outpatient visits, urgent care, and rehabilitation services. New York provides two sets of standardized plans, one that sets a deductible amount but requires the deductible to be met for most services, and another option in which three PCP visits are pre-deductible. (Basic Health provides low cost-sharing to modest income New Yorkers.) In Washington, the following services are not subject to silver deductibles: primary, specialty, and urgent care including outpatient behavioral health, therapies, labs and x-rays, generic and preferred drugs, ambulance services, eye exams for children.[ii] **CMS should adopt standard plan designs that move broad segments of preventive and outpatient care such as these to be pre-deductible.**

Network Adequacy

The Department indicates its intent to issue rules regarding network adequacy for the 2023 plan year and requests comments as to how it should approach network adequacy reviews. We formally submit the attached letter, which we have shared with this administration previously. **To summarize, the Department should:**

- Review the accuracy of provider directories, and make directories searchable by specialty, provider type, provider name *and* NPI[12], languages spoken, and physical accessibility;

[11]Cole et al, Association Between High-Deductible Health Plans and Disparities in Access to Care Among Cancer Survivors, JAMA, June 24, 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767589.

[12] A consumer recently contacted Families USA who could not locate his provider by name in any plan directory. The provider explained that it went by a different name in marketplace directories, and that we should search by NPI; however, we did not find NPI numbers in any links on healthcare.gov.

- Monitor appointment wait times;
- Monitor time and distance to travel to providers;
- Establish a network breadth indicator on healthcare.gov;
- Review out-of-network claims and denials, especially when the number of claims or denials creates a red flag; and
- Establish metrics appropriate for mental health and substance use services for each type of setting and level of care.

Attributing new coverage premiums to past due premiums

The Departments indicate that they are considering whether the 2017 rule, allowing insurers to attribute premium payments intended for new coverage instead to past due premiums, creates an unnecessary barrier to coverage and should change for 2023 (147.104).

We urge the Departments to change this rule beginning *in 2022*. The current policy specifically targets people who are struggling to pay monthly expenses, exacerbating health inequities. Health insurers should use other methods to pursue unpaid debts. We anticipate that consumers who have lost income during the pandemic, including those who did not learn how to access enhanced APTC, may have unpaid premiums as 2021 concludes. In some jurisdictions, laws or orders have required insurers to keep consumers' coverage intact during the public health emergency.[13] As the emergency ends and people return to work, consumers will need time to catch up on past due expenses and will need continued access to health coverage and care meanwhile.

Thank you for considering these comments. Please contact Cheryl Fish-Parcham, cparcham@familiesusa.org or Stan Dorn, sdorn@familiesusa.org, with any questions.

Sincerely,

Frederick Isasi

Executive Director, Families USA

[ii] https://casetext.com/case/city-of-columbus-v-cochran-1

[ii] https://www.wahbexchange.org/content/dam/wahbe/Wakely%20-%20WAHBE%202022%20Standard%20Plan%20Design%20Charts%20-%20Final.pdf

[13] For example, DC Commissioners' Order 01-2020, https://disb.dc.gov/sites/default/files/u65602/Order-re-Emergency-Response-to-COVID-19-03.20.2020-sec.pdf.