December 28, 2020

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

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

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

Dear Secretary Azar and Administrator Verma:

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

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

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

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

Codification of Prior 1332 Guidance

Our organizations previously objected to the 2018 guidance[2] that violated the statutory guardrails for waiver applications under Section 1332 of the ACA[3] and we strongly object to the current proposal to codify these guidelines in regulation. The 2018 guidance significantly undermines protections that ensure the quality and affordability of coverage for patients with pre-existing conditions. Codifying this guidance in regulation could cause lasting harm to vulnerable populations.

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

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

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

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

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

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

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

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

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

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

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

Elimination of the Exchanges

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

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

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

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

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

As noted in our previous comments[8] to the Department, we are concerned that transitioning to an insurer- and broker-facilitated enrollment system would reduce enrollment in plans with comprehensive coverage and would jeopardize quality and affordable healthcare coverage for patients. While insurance agents and brokers can play a role in helping individuals understand and enroll in health care coverage,[9] they may be subject to potential conflicts of interest as a result of the way that they are compensated.[10] Under the proposed guidelines, these entities may market non-ACA-compliant plans alongside QHPs, which may result in consumers purchasing lower-premium plans that in fact offer minimal coverage.

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

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

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

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

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

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

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

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

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

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

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

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[11] Appleby J. Short-Term Health Plans Boost Profits For Brokers And Insurers. *Kaiser Health News*. https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers. Published December 21, 2018.

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

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

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

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

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

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

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

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

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

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

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

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

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[18] 42 U.S.C. §18031(d)(4)(C) (2010). https://www.law.cornell.edu/uscode/text/42/18031 [emphasis added].
[19] 42 U.S.C. §18032(d)(3)(A) (2010). https://www.law.cornell.edu/uscode/text/42/18032.
[20] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. An Assister's Guide to Working with Agents and Brokers. https://marketplace.cms.gov/technical-assistance-resources/working-with-agents-and-brokers.pdf. Published October 2015.

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

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

Web-Brokers Should Not Be Permitted to Obscure Plan Details

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

Enhanced Special Enrollment Period (SEP) Verification

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

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

[21] Sentell T, Braun KL. Low health literacy, limited English proficiency, and health status in Asians, Latinos, and other racial/ethnic groups in California. *J Health Commun.* 2012;17 Suppl 3(Suppl 3):82-99. https://doi.org/10.1080/10810730.2012.712621.
[22] Buettgens M, Dorn S, Recht H. More than 10 Million Uninsured Could Obtain Marketplace

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

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

Research suggests that requiring additional documentation during SEPs discourages enrollment in QHPs, particularly among younger, healthier adults. In June 2016, CMS introduced a Special Enrollment Confirmation Process under which consumers enrolling through HealthCare.Gov during the most common SEPs were directed to provide documentation to confirm their eligibility. In the four and a half months after the program was implemented, SEP enrollment fell by 20 percent compared with the previous year.[25] During this time period, young adults were disproportionately likely to fail to complete the verification process: 45 percent of applications with a household contact ages 18-24 failed to submit additional documentation to verify a qualifying event, compared to 27 percent of those with a household contact ages 55-64.[26] Our organizations encourage further study of the impact of pre-enrollment verification, particularly with respect to the impact of these policies on Marketplace risk pools.

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

Coverage through Special Enrollment Periods. The Urban Institute. https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf. Published November 2015.

[23] Hancock J. Licking wounds, insurers accelerate moves to limit health-law enrollment. *Kaiser Health News*. http://khn.org/news/licking-wounds-insurers-accelerate-moves-to-limit-health-law-enrollment/. Published February 4, 2016.

[24] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program - 81 Fed. Reg. 94058 (2016). https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018.

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

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

[27] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Emergency and Major Disaster Declarations by the Federal Emergency Management Agency (FEMA) – Special Enrollment Periods (SEPs), Termination of Coverage, and Payment Deadline Flexibilities, Effective August 9, 2018 [Letter to All Federally-facilitated Exchange (FFE) Qualified Health Plan (QHP) and Stand-alone Dental Plan Issuers]. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf. Published August 9, 2018.

Changes to the Premium Adjustment Percentage Index (PAPI)
The 2022 NBPP proposes to increase the premium adjustment percentage, in accordance with the revised calculation methodology adopted in 2019.[28] We continue to oppose these changes and urge the Administration to revise their policy in this critical area. The proposed 2022 premium adjustment percentage reflects an increase of about 6.4 percent over the 2021 percentage. A higher premium adjustment means higher required contributions from consumers by decreasing premium tax credit amounts. Thus, this continued and accelerating growth under the new methodology shifts ever-greater costs onto families. Premiums for most subsidized marketplace consumers will increase 4.7 percent in 2022, according to analysis by the Center on Budget and Policy Priorities.[29] That increase amounts to a $360 premium increase for a family of four earning an $80,000 income. The limit on total out-of-pocket expenses will be $400 higher for individuals and $800 higher for families than they would be absent the 2019 methodology change. Increased marketplace premium and out-of-pocket costs will disproportionately impact lower-income individuals and those with higher healthcare needs. Facing these enormous costs, some individuals may choose to forgo necessary care, leading to costly and dangerous complications.

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

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

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

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[28] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Notice of Benefit and Payment Parameters for 2022 Proposed Rule Fact Sheet. https://www.cms.gov/files/document/proposed-2022-hhs-notice-benefit-and-payment-parameters-fact-sheet.pdf. Accessed December 2020.
[29] Straw, T. Trump Proposal Threatens Coverage of HealthCare.gov Enrollees. *CBPP.* 2020, Dec 7. cbpp.org/blog/trump-proposal-threatens-coverage-of-healthcaregov-enrollees. Accessed Dec 12, 2020.
[30] Multiple studies for the Medicaid population bear this out. See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." Center on Budget and Policy Priorities (July 2005), available at http://www.cbpp.org/5- 31-05health2.htm.
[31] The Commonwealth Fund. "Health Insurance Coverage 8 Years After the ACA". February 7, 2019. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
[32] Altman, Drew. "It's not just the uninsured – it's also the cost of health care". August 20, 2018. Available at: https://www.axios.com/not-just-uninsured-cost-of-health-care-cdcb4c02-0864-4e64-b745-efbe5b4b7efc.html.

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

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

Extension of the Temporary Premium Credits Through 2021

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

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

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

[34] Coronavirus in the U.S.: Latest Map and Case Count. *New York Times.* https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html. Updated December 14, 2020. Accessed December 2020.

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

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

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

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

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

Essential Health Benefit (EHB) Benchmark Flexibilities

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

Untimely Notice of an SEP Triggering Event

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

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

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

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

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

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

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

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

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

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

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

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

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[44] Wishner, Jane B., Ahn, Sandy, Lucia, Kevin, and Sarah Gadsen. Special Enrollment Periods in 2014: A Study of Select States. *Urban Institute.* 2015 Feb. https://nationaldisabilitynavigator.org/wp-content/uploads/news-items/UI_Special-Enrollment-Periods-2014.pdf. Accessed Dec 14, 2020.
[45] U.S. Department of the Treasury, Internal Revenue Service. Questions and Answers on the Premium Tax Credit. https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit. Updated November 24, 2020. Accessed December 2020.

SEP Eligibility Following Cessation of Employer Contributions to COBRA

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

Conclusion

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

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

Sincerely,

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

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

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

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

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

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