



December 30, 2020

Secretary Alex Azar
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on *HHS Notice of Benefit and Payment Parameters for 2022* Proposed Rule, CMS-2020-0009-0002

Dear Secretary Azar and Secretary Mnuchin,

We thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed 2022 Notice of Benefit and Payment Parameters (NBPP) rule. I Am Essential (IAE) is a broad coalition of organizations representing millions of individuals with serious and chronic conditions that is dedicated to protecting essential health care needs. The Affordable Care Act (ACA) has played a pivotal role in expanding coverage and guaranteeing essential health benefits for people living with serious, complex, and chronic conditions, and we look for ways to strengthen the law and thereby make healthcare more accessible and affordable.

The proposed 2022 NBPP includes provisions to which we strongly object as well as provisions that we support. This letter offers comments stemming from our unique insight as individuals for whom continuity of care, accessibility of comprehensive coverage, and affordability of life-saving medications are truly *essential*. We believe that health insurance must be structured to meet the healthcare needs of patients with serious and chronic conditions at all times, but especially during the ongoing coronavirus pandemic.

One overarching concern we have is that this rule was published with a constricted timeframe for comments that includes two national holidays. We urge you to extend the comment period for an additional 30 days to ensure that all stakeholders can carefully review and provide thorough and thoughtful feedback on these important policy changes. Health insurance is the gateway to healthcare for people in the United States, and this policy will impact how and whether millions of people are able to get the care they need in the wake of a national healthcare emergency.

Exchange Direct Enrollment

A significant portion of the 2022 NBPP is dedicated to codifying a new Exchange Direct Enrollment option for states. The new rule would facilitate states' transition away from using the centralized HealthCare.gov exchange for enrollment purposes, creating a process by which states may delegate control of the enrollment process to commercial entities without establishing their own health insurance exchange. This proposal undermines a core feature of the ACA (one-stop shopping) and would result in decreased access to health insurance, increased consumer confusion, and increased the likelihood that patients with serious and chronic conditions will end up with sub-par coverage.

Earlier this year, Georgia set the stage for this shift by applying for a Section 1332 waiver to leave the federal marketplace. In an application approved in November, the state contended that decentralizing the enrollment process would help bring down the state's high uninsured rate and increase the reach of insurance programs to underserved populations. In actuality, Georgia's departure from the federal exchange is expected to depress enrollment and leave tens of thousands of Georgians uninsured.¹ The same fate awaits other states if they opt for this path, should this rule be finalized as proposed.

Eliminating the one-stop-shop where consumers can compare plans and determine eligibility for premium tax credits or Medicaid will place undue burden on consumers as they navigate a complex constellation of provider services and enroll in plans. Health insurance should be offered in such a way that ensures a patient can find the plan that best fits their needs. For patients with serious, chronic conditions, understanding what is and is not covered by any given plan, and knowing how much their health care will cost, is paramount. Confusion about where and how to access good-quality health coverage will likely hinder enrollment and prompt many people to give up their search for coverage.

Additionally, there are concerns about allowing assisters to use web-brokers to enroll individuals. Brokers and insurers who operate through HealthCare.gov have a track record of engaging in fraud.^{2,3} Furthermore, there are cases of brokers directing consumers to less comprehensive plans, often based on the size of plan commissions.⁴ People enrolled in subpar plans are subject to punitive exclusions of their pre-existing conditions, benefit limitations, and caps on plan reimbursements that expose them to high out-of-pocket costs. One study from earlier this year showed that a popular short-term, limited duration plan in Atlanta refused to cover prescription drugs, mental health services, or maternity services; had pre-existing condition exclusions; and a deductible three times as high as an ACA-compliant plan.⁵ For people living with chronic conditions, these kinds of exclusionary benefit designs

¹ Tara Straw, "Tens of Thousands Could Lose Coverage Under Georgia's 1332 Proposal," Center on Budget and Policy Priorities, September 1, 2020. <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal>

² Ron Hertibise. "How Outright Lies Duped Victims of Health Insurance Scam" Sun Sentinel. December, 2018. <https://www.sun-sentinel.com/business/fl-bz-how-to-avoid-buying-bogus-health-insurance-20181219-story.html>

³ Bob Herman, "ACA Changes are Aiding Online Health Brokers" Axios. June, 2017. <https://www.axios.com/aca-changes-are-aiding-online-health-brokers-1513302640-5c7797c7-559f-4d3d-b235-117b6834e25c.html>

⁴ Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

⁵ Dane Hansen and Gabriela Dieguez, "The impact of short-term limited-duration policy expansion on patients and the ACA individual market," Milliman, February 2020, <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>; Kelsey Waddill,

that prevent a patient from accessing critical care and treatment pose a serious threat. Contrary to the promise of expanded choices, this direct enrollment proposal would take away consumers' only option available for a guaranteed, central source of unbiased information, and secure enrollment into comprehensive coverage.

Direct enrollment services are non-standardized and present additional barriers to consumers shopping for plans. Provider websites are often inconsistently and confusingly labeled and prevent consumers from comparing plans on a single portal, hindering competition among private insurance providers.⁶ As such, fracturing the enrollment system will place affordable, quality healthcare out of reach for consumers in Exchange Direct Enrollment states.

This new rule clears the way for other states to follow in Georgia's footsteps under simplified procedures. Eliminating the waiver process by which a state would apply to adopt a drastic marketplace enrollment system not only violates the ACA, it takes away the ability for invested stakeholders, including marketplace enrollees, to weigh in on a state's proposal.

We urge CMS to revoke the 1332 waiver approval for Georgia's direct enrollment plan and to withdraw this proposed rule change that would facilitate expansion of misnamed "Exchange Direct Enrollment" option.

Section 1332 Waiver

The 2022 NBPP moves to codify 2018 HHS guidance that weakens the guardrails that lie at the heart of Section 1332, allowing states to skirt requirements that protect vulnerable populations.⁷ Originally designed to promote innovation and allow states to pursue individualized approaches to expanded coverage, Section 1332 now risks losing its guardrails for good and undermining the original intent of the ACA. The letter of the law declares that waivers may be granted only if states demonstrate that their model meets federal standards of access and coverage. However, the 2018 guidance HHS released significantly relaxed how these guardrails are interpreted to the point of hollowing out these standards and putting patients, like those represented by I Am Essential, at risk.

One precarious facet of this guidance relates to the coverage access clause. Under the new standards, states will no longer have to demonstrate that coverage is being purchased under the waiver at rates commensurate to those under the ACA. Rather, states must merely show that similar numbers of residence have *access* to comprehensive coverage, disregarding their actual rate of enrollment. As a result, residents enrolling in sub-standard insurance with a lower premium will still be counted toward the state's comprehensive coverage rates so long as the ACA-compliant plan was available to them. This

"Do Short-Term Limited Duration Plans Deserve Industry Skepticism?," HealthPayerIntelligence, March 4, 2020, <https://healthpayerintelligence.com/news/do-short-term-limited-duration-plans-deserve-industry-skepticism>.

⁶ Tara Straw, "'Direct Enrollment' in Marketplace Lacks Protections for Consumers, Exposes them to Harm," Center on Budget and Policy Priorities, March 15, 2019. <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

⁷ CMS. "Overview of 1332 Guidance for State Relief and Empowerment" November 2018. <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/State-Relief-Empowerment.PDF>

shift in access standards obfuscates the on-the-ground impact of a given waiver and empowers states to undercut access to affordable and comprehensive insurance.

Likewise, changes in guidance regarding the coverage guardrail subvert the ACA's coverage standards. Under the rule, HHS will no longer require states' applications to include coverage that meets the ACA's standard of "minimum essential coverage." Rather, coverage will be assessed under either the ACA definition of "minimum essential coverage" or the far broader rubric of "health insurance coverage" defined in Title 45 of the Code of Federal Regulations. The latter standard would expand acceptable coverage to include short-term and association health plans, neither of which are comprehensive. With these changes, the new guidance would require HHS to consider private coverage when evaluating a waiver proposal.

In addition, the 2018 guidance shifts the focus of coverage away from vulnerable communities and toward the aggregate population of the petitioning state. Under prior guidance, state waivers could be denied if they were expected to reduce coverage among vulnerable residents, including those with chronic health conditions like HIV, epilepsy, multiple sclerosis, mental illness, lupus, and other serious conditions. However, the new guidance directs HHS to approve waivers that may lead to loss of coverage among vulnerable people given that the changes benefit the collective sum of state residents. While marginal groups still must be accounted for in the waiver proposal, they no longer occupy a central role in the waiver approval process. Without due consideration for those most at risk from loss of coverage, the new guidance upends efforts to protect those with chronic conditions.

We are particularly conscious of the effects of these guidance changes on individuals with high healthcare needs during this unprecedented time. Indeed, the proliferation of sub-standard insurance in waiver states risks heightening barriers that those living with these conditions already struggle to surmount, which will only be compounded by the challenges presented by COVID-19. As those with chronic diseases require consistent care, insufficient coverage could saddle them with medical debt or require them to miss treatments.

The erosion of ACA waiver guardrails will result in worse health outcomes of those living with chronic diseases and therefore, I Am Essential strongly objects to this proposal.

Essential Health Benefit Benchmark Timelines

While the 2022 NBPP does not propose new changes to the essential health benefit (EHB) benchmark plan selection and instead establishes a timeline for reporting, we would like to reiterate our opposition to the EHB flexibilities permitted in the 2019 NBPP. We believe that the change could invite states to cherry pick benefits, creating less comprehensive plans and increase out-of-pocket cost-sharing. 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. The essential health benefits set ACA plans apart and set the standard for meaningful coverage.

User Fee Reduction

In the 2022 proposed NBPP, HHS justifies further reducing the user fee to 2.25% for states that utilize the federally-facilitated exchange (FFE), and 1.75% for state-based marketplaces that use the federal platform (SBE-FPs). This user fee provides the necessary funds to support critical functions of the exchange, such as operations, management, and improvements of Healthcare.gov and the call center. It

also supports critical outreach services including the navigator program and advertising. These services in particular have experienced a significant reduction in funding over the last few years; the navigator program in particular has been cut by 84% since 2017.⁸ Lowering the user fee, and thereby reducing the overall funds to help cover those expenses, will jeopardize critical services that are already underfunded.

Navigators play an important role in providing the necessary assistance to get people enrolled in a plan, the essential first step to ensuring patients have access to health care. They are particularly valuable in helping new enrollees, and in situations of complex eligibility cases. As a result of the public health pandemic, with expected lingering effects, the navigator program and navigators will be instrumental in assisting people through the transition to the ACA market. To sufficiently support the demand for navigators, and to restore other outreach and marketing activities, the user fee should not be reduced, as proposed, but increased.

We strongly oppose this proposed rule change, and urge HHS to increase funding for outreach and enrollment assistance to help increase enrollment and ensure that people with complex health needs are able to choose the best plan for them and their families.

Special Enrollment Periods

The 2022 NBPP proposes several changes and new options related to special enrollment periods (SEPs). As the pandemic persists, and the economic crisis continues, it can be expected that many individuals and families will experience fluctuating financial circumstances into 2022 as the job market begins to rebuild. Individuals previously eligible for a premium tax credit, who experience a change in income making them newly *ineligible* for APTC, should have the opportunity to return to the marketplace to shop for a plan that continues to meet their healthcare needs, and is feasible for their budget. I Am Essential agrees with HHS's reasoning that eligibility for APTC can influence a consumer's decision when selecting a plan and supports this provision that can help ensure patients maintain coverage. Similarly, I Am Essential supports the proposal to allow individuals who become newly *eligible* for APTC to have the same freedom in selecting a plan. Imposing restrictions on consumers' choice under these circumstances to specific metal level tiers seems unnecessary; consumers should have the flexibility to select any plan that they find affordable.

As a result of the public health pandemic millions of people have lost work, and with their jobs, their employer-sponsored health insurance. Several studies estimate that anywhere between 10 and 30 million workers and their dependents will lose their job-based health insurance as a result of the economic downturn.⁹ Some former employees have been able to maintain their health insurance through COBRA. However, as the pandemic stretches on, more employers may have to reduce or

⁸ Katie Keith, "CMS to Maintain Navigator Funding at \$10 Million for 2020, 2021." Health Affairs Blog. May 29, 2019.

<https://www.healthaffairs.org/doi/10.1377/hblog20190529.659554/full/#:~:text=Since%20the%20Trump%20administration%20took,only%2039%20grantees%20for%202019.>

⁹ Jessica Banthin. John Holahan. Urban Institute. *Making Sense of Competing Estimates: The COVID-19 Recession's Effect on Health Insurance Coverage*. August 2020.

https://www.urban.org/sites/default/files/publication/102777/making-sense-of-competing-estimates_1.pdf

eliminate their contributions to COBRA coverage. While an SEP is already in place for individuals whose employers stop paying for their portion of the COBRA premium, qualifying them for a loss of minimum essential coverage, this does not extend to plans sold “off” exchange, or to state-based marketplace plans. Access to coverage is of utmost importance to patients. Improving access across the individual market due to a reduction or cessation of payments by the employer, making COBRA coverage unaffordable, is a step in the right direction to ensuring patients have no interruptions in their care.

Lastly, we are concerned about the proposal to require exchanges verify at least 75% of new enrollments during a special enrollment period. I Am Essential believes this adds unnecessary processes to a system that already has established verification procedures in place, and creates barriers to accessing coverage for patients during tumultuous times of health insurance transition. This is especially critical given the high rates of coverage loss during the ongoing COVID-19 pandemic, during which access to SEPs has been critical for ensuring that consumers remain insured during a public health crisis.¹⁰ We oppose this portion of the proposal in its entirety and urge HHS to focus its efforts on expanding access to coverage, especially during a global pandemic.

Changes to the Premium Adjustment Calculation and Extending Temporary Premium Credits

In the past I Am Essential has expressed our concern regarding changes to the premium adjustment percentage calculation and the impact it has by raising premiums, increasing the annual out-of-pocket limit, and cutting financial assistance for millions of individuals. Patients are continuously being burdened by increasing costs, making healthcare and prescription drugs unaffordable. The provision proposed in the 2022 NBPP will continue to put healthcare out of reach by adding \$400 to the annual out-of-pocket costs, bringing the maximum to \$9,100. Even before the pandemic, many individuals and families reported living paycheck to paycheck, unable to afford a \$400 unexpected bill.¹¹ Now, in the context of an economic crisis, continuing to use a formula that raises premiums and annual limits to such heights as \$9,100 seems cruel and counter to the intent of the Affordable Care Act. I Am Essential believes reverting to the calculation utilized prior to 2020 would better balance patient affordability while still accounting for premium growth.

The public health pandemic that has endured throughout 2020 has highlighted the precarious nature of healthcare. In response, HHS released several pieces of guidance relaxing requirements for issuers and easing the burden of maintaining continuous coverage for patients. In August, CMS offered issuers flexibility to reduce premiums for consumers struggling to pay their premiums to help ensure their continued coverage and ability to receive care as needed. The 2022 proposal seeks to codify this temporary flexibility to allow issuers to grant the same concessions to beneficiaries should a future

¹⁰ “Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency,” Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services (Nov. 2020), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-Nov-2020.pdf> (finding that 485,000 consumers gained coverage through the loss of MEC SEP in 2020, an increase of 52 percent from the same time period last year).

¹¹ Alina Selyukh. NPR. Paycheck to Paycheck Nation: Why Even Americans with Higher Income Struggle with Bills. December 16, 2020. <https://www.npr.org/2020/12/16/941292021/paycheck-to-paycheck-nation-how-life-in-america-adds-up>

public health emergency be declared. I Am Essential supports this proposal as a responsible policy that will protect patients' access to care.

PBM Reporting

Pharmacy benefit managers (PBMs) have an increasing role in the health insurance system and prescription drug benefit management. However, information on PBM operations is not transparent. In Medicare, PBMs are required to report on certain prescription drug distribution and cost data which provides insight into the role PBMs play, methods used, and revenue generated. The 2022 NBPP would require PBMs to report on the same information they provide in Medicare, and that qualified health plan (QHP) issuers must account for in the individual market. PBMs must report to the Secretary of HHS, as required by section 1150 A, the percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; generic dispensing rates; total amount and type of rebates, discounts, or price concessions that the PBM negotiates and the totals that are passed through to the plan sponsor; and the aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail and mail order pharmacies. I Am Essential believes that requiring this reporting will provide some visibility and accountability of PBM operations.

In closing, while the proposed 2022 NBPP does not address patient copay assistance, I Am Essential would like to reiterate the importance of this financial support for patients to afford life-saving medications, and urge HHS to reconsider its policy allowing insurance issuers and pharmacy benefit managers to adopt copay accumulator adjustment programs. A recent review of 2020 and 2021 marketplace plans reveals that copay accumulator adjustment programs have proliferated in the past two years.¹² These policies disproportionately impact patients with chronic illness, jeopardizing their access to needed care and prescription drugs. I Am Essential urges HHS to require issuers and pharmacy benefit managers to count patient copay assistance toward a beneficiary's out-of-pocket costs, putting patients' health first.

I Am Essential is committed to working with CMS, bringing the voice of those who rely on Healthcare.gov and their state-based exchanges to the table and to provide insight on how the implementation of these policies will impact their ability to access healthcare and live healthy lives. Thank you very much for your consideration of our comments. Should you have any questions, please contact: Rachel Klein, Deputy Executive Director, The AIDS Institute, rklein@tmail.org; Laura Weidner, Vice President, Government Relations and Advocacy, Epilepsy Foundation, lweidner@efa.org; or Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance on Mental Illness, asperling@nami.org.

Sincerely,

ADAP Advocacy Association
AIDS Alliance for Women, Infants, Children, Youth & Families
Allergy & Asthma Network

¹² Stephanie Hengst. The AIDS Institute. Copay Accumulator Adjustment Programs: Putting Insurance Company Profits Over Patients. June 2020.

http://www.theaidsinstitute.org/sites/default/files/attachments/AI_CoPay_Accumulator_Adjustment_Brochure_w%20Appendix_FINAL.pdf

American Association on Health & Disability
Arthritis Foundation
California Hepatitis C Task Force
Caregiver Action Network
Community Access National Network (CANN)
Consumers for Quality care
Epilepsy California
Epilepsy Foundation
International Association of Hepatitis Task Forces
International Myeloma Foundation
International Pemphigus and Pemphigoid Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
MLD Foundation
National Alliance on Mental Illness
National Hemophilia Foundation
Rush to Live
Spina Bifida Association
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The AIDS Institute
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