July 28, 2021

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

RE: RIN 0938–AU60; CMS-9906-P

Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Dear Administrator Brooks-LaSure:

We the undersigned members of the Consortium for Citizens with Disabilities Health Task Force appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule - Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond (hereinafter "UPP Rule").

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

We support many of the proposals in the UPP Rule which will expand enrollment opportunities, reduce the number of uninsured persons, and restore important Affordable Care Act (ACA) programs and protections.

Enrollment Opportunities in Health Care Marketplaces

According to the Congressional Budget Office, more than one-third of people who are uninsured are, in fact, eligible for Medicaid or for premium tax credits (PTCs) in the Marketplace. We strongly support extending the open enrollment period and establishing a Special Enrollment Period (SEP) for low-income persons, as well as other strategies that will reduce the number of uninsured.

Guaranteed Availability of Coverage - § 147.104

CMS is reconsidering its interpretation that persons who owe past due premiums are prohibited from enrolling in coverage until they satisfy arrearages. We strongly support revising this provision. The ACA is clear – an issuer "must accept every employer and individual in the State

820 First Street, NE Suite 740 • Washington, DC 20002 • PH 202-567-3516 • FAX 202-408-9520 •
Info@c-c-d.org • www.c-c-d.org

that applies for such coverage.” (42 U.S.C. 300g-1) This policy of prohibiting people with past due premiums from enrolling in coverage is in violation of the law and has created significant hardship for individuals. It also allows for issuers to block consumers from enrollment due to accounting irregularities that were not the consumer’s fault. For example, some consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer’s account, or issued bills that did not match the amount consumers were supposed to pay.

Essential Health Benefits - § 156.100 and 110

Starting for plan year 2019, CMS allowed states to change their EHB benchmark plan annually by selecting the EHB-benchmark plan that another State used for the 2017 plan year, replacing one or more EHB categories of benefits its EHB benchmark plan with the same categories of benefits from another State’s EHB-benchmark plan, or otherwise select a set of benefits that would become the State’s EHB benchmark plan.

Our coalition expressed our concern with this approach in 2017. CCD was concerned that states would select a more limited benefit package than they currently offer. Rehabilitation and habilitation services and devices, mental health and substance use disorder services, prescription drugs, and the other EHBs are simply too important to allow States to substantially limit these benefits in redefining new EHB benchmark plans. We urge CMS to review and rescind this policy. Please see our previous comments on the Notice of Benefit and Payment Parameters for plan year 2019 and 2020 for more detail.

Navigator Program Standards - § 155.210

The UPP Rule would reinstate previous requirements for Navigators to assist consumers in certain post-enrollment activities. In particular, Navigators would be required to help consumers: 1) file appeals on Exchange eligibility determinations; 2) understand basic concepts and rights associated with health coverage (such as explaining complex terms like deductible or coinsurance or helping them navigate drug formularies and provider networks); 3) apply for an exemption to maintaining minimum essential coverage from the exchange; 4) help consumers reconcile APTCs; and 5) find assistance with tax filing.

Evidence shows that millions of people find the process of applying for and using health insurance overwhelming. Many do not have basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. In addition, people with disabilities often have complex health care needs that may not be addressed by every health plan. Thus, having assistance from a trained Navigator with finding a plan that covers their medications and allows them to maintain their providers, is critical. Navigators can also help reduce health disparities by improving health literacy in rural and underserved communities, including among Black, Indigenous, and other people of color. Given this, it is vital that Navigators be required not only to help consumers enroll in health coverage, but also be available to assist with post-enrollment activities.

Finally, while we support the proposal to require Navigators to engage in post-enrollment activities, we are concerned that CMS did not propose to restore the requirements to have at least two in-person Navigator organizations in each state and to ensure that at least one of those

organizations was a trusted community nonprofit. Face-to-face assistance is often critical to build trust with applicants and to explain the various components of application, plan selection, resolving data matching inconsistencies, and assisting with appeals. Community entities with a physical presence will better know their communities and be better able to serve them because they likely interact with the target populations on an ongoing basis and are able to build relationships that transcend the application process. In-person assistance is especially critical in rural and underserved communities where people may not have reliable access to a computer or telephone. We recognize that CMS is currently reviewing navigator grants applications and will likely select them prior to the finalization of these rules. Therefore, we would strongly suggest CMS consider having at least two in-person Navigator entities in every state and ensuring at least one of those entities is a consumer-facing nonprofit.

Direct Enrollment - § 155.221(j)

The UPP Rule would repeal a provision allowing "direct enrollment" exchanges, which would circumvent the ACA Marketplaces and allow insurers and web brokers to operate enrollment websites through which consumers could apply for and enroll in coverage. We previously expressed significant concerns with this policy and we strongly support repealing this provision.

As CMS notes, direct Enrollment lacks key consumer protections and is contrary to the ACA's "No Wrong Door" policy. We were particularly concerned that substandard plans, such as short-term plans, would be presented alongside comprehensive insurance. People enrolled in subpar plans are subject to punitive exclusions of their preexisting conditions, benefit limitations, and caps on plan reimbursements that expose them to potentially high out-of-pocket costs. Without access to a single comprehensive enrollment website, consumers may be steered, or simply confused, and enroll in plans that do not meet their needs or comply with the ACA. People who are eligible for Medicaid may not know it and not be enrolled. Worst of all, some people may end up with no coverage at all. A recent report from leading patient advocacy organizations detailed the risks of Short Term Limited Duration Plans, Health Sharing Ministries, and other health plans and insurance-like products that do not comply with key ACA protections, including Essential Health Benefits, and exposed that web brokers often steer consumers to these plans.

This is a particular concern for people with disabilities, who often have higher health care needs. In addition to leaving some without coverage when they need it, promoting enrollment in substandard or short-term plans also leads to a bifurcation of the risk pool, which can result in higher overall premiums in comprehensive Marketplace plans that people with disabilities are more likely to need. This is exactly the situation the ACA sought to eliminate.

Kaiser Health News reported the story of a man steered into a skimpy short-term plan by a broker; he only discovered it wasn't an ACA-compliant plan after his cancer diagnosis. The Government Accountability Office (GAO) recently released a study that revealed similar practices among agents and brokers. Enrolling in sub-par plans is of particular concern for people with disabilities and chronic conditions who need comprehensive coverage. The public needs a one-stop-shop, conflict-free enrollment website, such as HealthCare.gov and current state Exchange websites. We support the decision to repeal this provision.

Expanded open enrollment - § 155.410
CMS proposes to extend the annual open enrollment period for the Federally Facilitated Marketplaces (FFMs) to January 15. We support this change and urge CMS to extend the deadline even further to January 31. As state-based marketplaces' experience has shown, extending open enrollment greatly benefits consumers and helps reduce the number of uninsured. CMS should also make clear that the federal open enrollment period is the floor and that states can have longer enrollment periods. We encourage CMS to go further and align the start of open enrollment with the start of Medicare open enrollment on October 15. Many people do not know what kind of health coverage they have, or what coverage they may be eligible for. The outreach to potential Medicare beneficiaries or Marketplace enrollees would cross pollinate and encourage more people to explore their coverage options. Applying for health insurance and selecting a plan can be challenging and has significant impact on someone's finances and health. For many people with disabilities, buying health insurance is one of the most complicated, and consequential, financial decisions they make. Requiring people to make these important and complicated decisions in just a few weeks during the holiday season makes it more difficult to get the best coverage.

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

Special enrollment period for low income persons - § 155.420
The UPP Rule would establish a new SEP for individuals and dependents who are eligible for advance premium tax credits (APTCs) and whose household income is under 150 percent of the federal poverty level (FPL). The low-income SEP would allow those eligible to enroll at any time during the year based on their income or upon learning of their eligibility. We strongly support this proposal.

SEPs that are currently available can be so overly complex and restrictive that few of the people qualify actually use SEPs. A new, year-round SEP for low income people would reduce the number of uninsured. Some states already provide year-round enrollment to low-income people without any significant signs of adverse selection. In Massachusetts, people with incomes up to 300 percent of poverty (about $36,000 for an individual or $75,000 for a family of four) can generally enroll in marketplace coverage year-round.

Data from 2020 state COVID-related SEPs in Colorado, the District of Columbia, and Massachusetts show that opening enrollment and reducing barriers to SEPs may actually attract younger and subsequently healthier enrollees.

Easing barriers to SEPs has been an important strategy to counter COVID-19. According to CMS, more than 1.5 million people signed up for coverage via HealthCare.gov between February 15 – June 30 under the COVID-19 SEP. We fully expect the final data from the SEP to show that adverse selection was not a factor influencing enrollment, particularly those who qualify for $0 premium coverage.

User Fee Rates for the 2022 Benefit Year - § 156.50
In the UPP Rule, CMS proposes a modest increase to user fees of 2.75 percent for FFMs. The Marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. Navigators and other in person assistance are especially important to people with disabilities who may need extra assistance enrolling in coverage that meets their needs. Under the previous administration, CMS slashed user fees and virtually ceased marketing and outreach and slashed funding for Navigators, core marketplace functions funded by user fees.

User fees are essential to operate the Marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. These include enhancing the consumer experience through improvements to the application and HealthCare.gov, as well as addressing other behind-the scenes issues. We believe CMS should increase user fees and make much needed fixes and enhancements to Marketplace enrollment.

Network Adequacy - § 156.230
Our coalition has strongly supported strong federal network adequacy standards. Robust provider networks are particularly important for people with disabilities and chronic conditions. People with disabilities need access to robust provider networks that provide access to a range of physically accessible, qualified providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long waiting times. In addition to physically accessible primary care, such provider networks should include physician specialty services such as physical medicine and rehabilitation, neurology, orthopedics, rheumatology, and many other subspecialties, including physicians serving pediatric populations. They should include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs), skilled nursing, home health, and home and community-based services. They should also include physical, occupational, and speech-language therapy, audiology services, and recreational and respiratory therapy. Durable medical equipment specialists and appropriately credentialed prosthetists and orthotists must also be included in provider networks as well as clinicians engaged in psychiatric rehabilitation, behavioral health services, cognitive therapy, and providers of psycho-social services provided in a variety or inpatient and/or outpatient settings.

CMS requests comments and input regarding how the federal government should approach network adequacy reviews. Reviews should include whether the provider network is sufficient to deliver culturally competent, non-biased care, and with providers and their equipment fully accessible to persons with disabilities. One enforcement tool would be to review the number of out-of-network claims denials and assess plans with high numbers of out-of-network denials for their size. High rates of denials should prompt further review.

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

We urge strong CMS oversight of the QHP certification process, including and especially with regard to network adequacy.

Restoration of Section 1332 Waiver Guardrails - §§ 33.108-33.132, 155.1308, 155.1318
The UPP Rule would reverse attempts to undermine important guardrails governing Section 1332 waivers. The ACA's 1332 guardrails require that waivers cover at least as many people, with coverage at least as comprehensive and affordable as would be the case without the waiver, without increasing the federal deficit. We strongly support the proposed changes. We particularly support the requirement for states to conduct an analysis of the impact of a waiver across groups, including low-income individuals, older adults, those with serious health issues or at the risk of developing serious health issues, and people of color.

Specifically with regard to § 155.1318, the UPP Rule proposes to allow states to avoid adequate public notice and opportunity to comment for Section 1332 waivers in certain "emergent situations" such as natural disasters, public health emergencies, and other situations. Requirements for Section 1332 public notice and opportunity for a "meaningful level of public input" are statutory, designed to ensure public input and transparency in state efforts to transform their health delivery systems. Section 1332 waivers are designed to implement health system innovations, not to respond to disasters and other emergencies. Congress has provided other authority to respond to natural disasters and other emergencies. We urge CMS to withdraw this proposal.

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

However, we object to the truncated 30-day comment period. We also strongly object to tolling the comment period from the posting of the public inspection version, and not the actual Notice of Proposed Rulemaking published in the Federal Register. This practice undermines the intent and purpose of the Administrative Procedure Act and must not become the norm in rulemaking.

Thank you for the opportunity to comment on this important issue. If you have further questions, please contact David Machledt at the National Health Law Program at Machledt@healthlaw.org and Rachel Patterson at the Epilepsy Foundation at rpatterson@efa.org.

Sincerely,

American Association on Health and Disability and Lakeshore Foundation
American Council of the Blind
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Therapeutic Recreation Association

Autistic Self Advocacy Network
Brain Injury Association of America
Disability Rights Education and Defense Fund (DREDF)
Easterseals
Epilepsy Foundation
Justice in Aging
National Alliance on Mental Illness
National Center for Parent Leadership, Advocacy, and Community Empowerment (National PLACE)
National Health Law Program
National Multiple Sclerosis Society
Spina Bifida Association
The Arc of the United States
United Spinal Association