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:

On behalf of the National Urban League and its 91 local affiliates across 36 states and the District of Columbia, we write to express our support for 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").

National Urban League appreciates the opportunity to comment. We encourage 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

We strongly support CMS's proposed changes to improve and expand enrollment opportunities in Marketplace plans, including by extending the open enrollment period and establishing a Special Enrollment Period (SEP) for low-income persons. According to the Congressional Budget Office, more than one-third of people who are uninsured are, in fact, eligible for Medicaid or for premium tax credits (PTCs) in the Marketplace. These strategies will go a long way to reduce the number of people who are uninsured. This is vitally important as we continue to fight against the COVID-19 pandemic and address its disparate impact on communities of color and low-income individuals.

Guaranteed Availability of Coverage - § 147.104

We support CMS's reconsideration of its interpretation that persons who owe past due premiums are prohibited from enrolling in coverage until they satisfy arrearages. This policy has created significant hardship for individuals. For example, some consumers regularly paid their premiums but the issuers either failed to match the payment to a particular consumer's account, issued bills that did not match the amount consumers were supposed to pay, and other accounting irregularities that were of no fault to the consumers. The ACA is clear – an issuer "must accept every employer and individual in the State that applies for such coverage." (42 U.S.C. 300g-1)

As we recover from a pandemic that has disproportionately harmed people of color, economically and physically, this policy change is of the most importance.

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 also shows that millions of people find the process of applying for and using health insurance overwhelming. Many lack basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. Additionally, they can help reduce health disparities by improving health literacy in urban, rural, and underserved communities, including communities 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.

Our National Urban League affiliates have played a significant role in the Navigator program, assisting clients to understand their choices and exercise their agency in the health insurance Marketplace. Our affiliates offer the support of their organization and our nation-wide Urban League network, providing accurate and comprehensive health literacy guidance to underserved communities.

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 obtain the trust of applicants and to help walk them through the various components of application, plan selection, resolving data matching inconsistencies, and assisting with appeals. Community-based organizations

with a physical presence will better know their communities and be better able to serve them. Organizations like the Urban League already interact with the underserved populations on an ongoing basis and are able to build relationships above and beyond the application process. In-person assistance is especially critical in communities where people may not have reliable access to a computer, telephone or linguistically competent services—disproportionately communities of color and low-income communities. We strongly suggest CMS consider reinstating the requirements to have at least two in-person Navigator entities in every state and to ensure that at least one of those entities is a consumer-facing nonprofit.

The value that community-based organizations like the National Urban League bring to the health literacy and navigator landscape is invaluable. The National Urban League, in particular, has been cultivating multi-generational relationships and advocating in communities across the country since our founding in 1910. Our affiliates work with and in the communities that can benefit most from healthcare literacy, and we fully believe in the power of face-to-face support.

Direct Enrollment - § 155.221(j)

We strongly support the UPP Rule's proposed repeal of a provision allowing "direct enrollment" exchanges. These exchanges circumvent the ACA Marketplaces and allow insurers and web brokers to operate enrollment websites through which consumers could apply for and enroll in coverage.

As CMS notes, direct Enrollment lacks key consumer protections and is contrary to the ACA's "No Wrong Door" policy. Moreover, as a recent report from the Leukemia and Lymphoma Society and approximately thirty other patient advocacy organizations exposed, web brokers often steer consumers to Short Term Limited Duration Plans, Health Sharing Ministries, and other health plans and insurance-like products that do not comply with key ACA protections including Essential Health Benefits.

ACA Marketplaces help to make information about available plans accessible and comparable, all in one place. Meanwhile, direct enrollment can be particularly harmful for individuals who lack healthcare literacy, or knowledge about the specific requirements of the ACA to know whether the plan they are looking at is compliant or not. This means that underserved communities are at a higher risk for being harmed by a plan that does not provide sufficient coverage, contains hidden costs, or is prohibitively expensive.

Expanded open enrollment - § 155.410

We support CMS's proposal to extend the annual open enrollment period for the Federally Facilitated Marketplaces (FFMs) to January 15. We urge CMS to extend the deadline even further, to January 31. As states' experience has shown, extending open enrollment greatly benefits consumers and helps reduce the number of uninsured. We support the model of California and New Jersey, which have extended open enrollment

to January 31 in the FFMs and require that coverage to begin February 1. Applying for health insurance and selecting a plan can be challenging and has significant impact on someone's finances and health. For many consumers, buying health insurance is one of the most complicated, and consequential, financial decisions they make, second only to buying a car or a house. Requiring people to make these important and complicated decisions in just a few weeks during the holiday season 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.

Extending the open enrollment period should be the goal for every state that has not yet done so. Allowing individuals additional time to navigate their coverage options gives them a chance to make better informed choices for their health and financial futures. For people of color and low-income individuals, who disproportionately lack digital literacy and broadband access, limits on the enrollment period are another barrier to care. It is imperative that the open enrollment period be extended so that all Americans can have adequate time to get the help they need and make the best choices for themselves and their families.

Giving people more time to enroll means that more people can enroll in health coverage and select the plan that is best for them. Extending open enrollment will greatly benefit consumers and help reduce the number of uninsured.

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 who 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 federal to show that adverse selection was not a factor influencing enrollment, particularly those who qualify for $0 premium coverage.

Low-income individuals face compounded barriers to obtaining health insurance – in addition to lack of access to the internet and necessary devices, they may face language or cultural barriers, lack of awareness, or misinformation and misunderstanding about what is inarguably a complex system. Outreach and education efforts help to combat these barriers and arm people with the information they need to make a decision that benefits them.

Double billing and segregation of funds for abortion services - § 156.28

The UPP Rule would rescind the 2019 Trump administration "double billing" rule, which requires issuers to send separate premium bills on abortion services to consumers and to instruct consumers to pay a separate bill in a separate transaction. The double billing rule would have impeded access to abortion care, with devastating results for individuals and families. We strongly support rescinding this rule.

Abortion is health care -- a common and safe medical intervention, and a legally and constitutionally protected form of medical care in the United States. For many, coverage for abortion care means the difference between getting the health care they need when they need it and being denied that care. Individuals denied abortions are more likely to experience eclampsia, death, and other serious medical complications, remain in relationships where interpersonal violence is present, and suffer anxiety after being denied an abortion. We support the repeal of the 2019 changes to §156.280.

User Fee Rates for the 2022 Benefit Year - § 156.50

In the UPP Rule, CMS proposes a modest increase to user fees - 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. 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.

Consumer outreach and advertising help to make people aware about the options that exist, their eligibility, and where they can go to get more information and/or any assistance they may need. And, as mentioned above, the Navigator program has been

vital to getting people of color and low-income people the health insurance they need. Lack of insurance is a huge barrier to health care in this country. It is of the most importance that the federal government supports Navigator programs and reaches consumers of color and low-income consumers with targeted advertising and outreach. The increased funding stream in this proposal would go a long way towards these goals: getting folks insured and ensuring they have access to the high-quality care they need and deserve.

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

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, anti-bias care, and with providers 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.

Living through a pandemic that has harmed the health and economic security of people of color at much higher rates than their White counterparts and given the racial reckoning that began in 2020 and has continued throughout 2021, ensuring that providers are culturally competent, anti-bias, and accessible to persons with disabilities is more important than ever. People of color, people with disabilities, and other historically and systemically marginalized persons should not have to face additional discrimination when they try to obtain healthcare. Reviewing whether the provider network is sufficient to deliver culturally competent, anti-bias care, and with providers fully accessible to persons with disabilities is of the utmost importance.

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 support the proposed changes.

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.

As we continue to deal with the effects of a climate crisis, natural disasters are hitting communities of color and low-income communities the hardest. It is exactly in times of disaster that transparency and public input are vital, as checks on the system to hold it accountable to serving the most vulnerable among us. To allow Section 1332 waivers during these times is to undermine this ideal.

Conclusion

Lastly, we object to the truncated 30-day comment period and 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 Morgan Polk or Susie Feliz at National Urban League, mpolk@nul.org, sfeliz@nul.org.

Sincerely,

Marc Morial
President, CEO
National Urban League