EVERY TEXAN

Formerly Center for Public Policy Priorities

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: CMS-9906-P; RIN 0938–AU60; *Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule*

Dear Administrator Brooks-LaSure:

Every Texan appreciates the opportunity to submit comments in response to the proposed rules "Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond" from the Department of Health and Human Services and the Center for Medicare and Medicaid Services.

At Every Texan (formerly Center for Public Policy Priorities), we envision a Texas where people of all backgrounds can contribute to and share in the prosperity of our state. The Benedictine Sisters of Boerne, Texas, founded Every Texan in 1985 to advance public policy solutions for expanding access to health care. We became an independent, tax-exempt organization in 1999. Texas faces long-standing challenges to optimal health, including the nation's highest uninsured rates, and steep financial and systemic barriers for those who have insurance. We work to improve public policies to make affordable, comprehensive health care a reality for every Texan. We are based in Austin, Texas, and work statewide.

We support the proposed rules and believe that they will lead to coverage of more uninsured individuals due to expanded enrollment opportunities and will restore key Affordable Care Act protections.

Part 147— Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

PAST-DUE PREMIUMS § 147.104

The agency's current interpretation of guaranteed availability, which prevents some people who owe past-due premiums from enrolling in coverage until they have paid back premiums, presents a substantial barrier to accessing health coverage for some consumers. We strongly encourage you to address this interpretation the 2023 Payment Notice rulemaking. 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).

Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

NAVIGATOR PROGRAM STANDARDS § 155.210

Every Texan works closely with enrollment assisters across Texas, including both Navigators and Certified Application Counselors, who are charged with helping consumers apply for and enroll in the Marketplace, Medicaid, and CHIP by providing impartial information in a manner that is culturally and linguistically appropriate.

We strongly support provisions in the proposed rule that 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.

A recent Kaiser Family Foundation survey revealed that 61% of consumers with Marketplace coverage found at least one aspect of enrollment difficult. Unsurprisingly, an even higher share – 83% – of uninsured consumers who sought coverage but who were unable to enroll reported difficulty with the process. The survey also illustrated the need for post-enrollment assistance, finding that 27% of consumers who received enrollment assistance returned to their assister for post-enrollment help, such as understanding how to use their new coverage. In-person enrollment assistance and post-enrollment support by Navigators can greatly reduce the complexity inherent in applying for and using health coverage. Because Navigators are charged with serving underserved communities, their enrollment assistance and post-enrollment support can also help reduce health inequities.

We urge CMS to also reinstate previous Navigator program requirements that there must be at least two Navigator organizations in each state; that at least one of those organizations would be a trusted community nonprofit; and that Navigators maintain a physical presence in the state. Remote enrollment assistance options have been vital during the pandemic, but that work was built on the foundation of trust and relationships that community groups working locally fostered over time, and remote-only assistance will be harder for underserved communities to access, particularly if they lack reliable computer or telephone access.

EXCHANGE DIRECT ENROLLMENT OPTION § 155.221(J)

We support the proposal to repeal the provisions allowing "direct enrollment" Exchanges. These problematic provisions would allow states to make sole use of private sector entities such as Web brokers to enroll consumers in Exchange coverage in lieu of centralized, public Exchanges.

This approach can harm consumers because direct enrollment websites often lack key consumer protections, including that:

- Direct enrollment websites undermine the ACA's "No Wrong Door" policy by steering consumers from the Marketplace application that would facilitate access to, and eligibility for, other programs such as Medicaid and the Children's Health Insurance Program (CHIP), toward non-ACA products.
- Many direct enrollment websites offer plans that do not comply with ACA standards and use screenings tools that are designed to shift consumers to non-ACA compliant plans for which insurance agents and brokers receive higher commissions.
- Some direct enrollment websites prevent consumers from comparing all ACA-compliant products based on price and quality because they offer enrollment only in a sub-set of available plans.

For these reasons, we agree with CMS that the Direct Enrollment Exchange option would "harm consumers by unnecessarily fracturing enrollment processes," and fully support repeal of the Exchange Direct Enrollment option.

OPEN ENROLLMENT PERIOD EXTENSION § 155.410(E)

We support CMS' proposal to extend the annual open enrollment period in the Federally Facilitated Marketplace to January 15 each year, and urge CMS to extend the deadline even further.

As state-based Marketplace experience has shown, extending open enrollment benefits consumers and helps reduce the number of uninsured. CMS should follow the lead of California and New Jersey, as states that extended enrollment times, and extend open enrollment to January 31 in the Federally Facilitated Marketplace and require coverage to begin February 1.

Providing this additional time for open enrollment makes sense. Applying for health insurance and selecting a plan can be challenging and the choice of a plan can significantly impact both finances and health. Requiring people to make these important and complicated decisions in just a few weeks, and during the holiday season, makes it more difficult for consumers to get the best coverage for them. Extending open enrollment to January 31 would be especially valuable for those consumers who are auto-reenrolled into coverage, but will receive a lower subsidy than they did in the prior year because of a change in the benchmark plan. These enrollees may have to contribute a higher level of premium

towards coverage. Because these consumers are auto-reenrolled, they are often unaware of their higher premium contribution until they receive their bill in early January. We are concerned that extending the open enrollment period only through January 15th would not allow sufficient time for consumers to seek out assistance, shop, and select a different plan after they have obtained their January premium bill. In addition, to extending the open enrollment period through January 31st, HHS should perform targeted outreach to consumers who have been auto-enrolled and their premium has increased to let them know they can still change plans for the upcoming year.

MONTHLY SPECIAL ENROLLMENT PERIOD FOR LOW INCOME CONSUMERS § 155.420(D)(16)

We strongly support the proposal to establish a new special enrollment period (SEP) for individuals and dependents who are eligible for Advance Premium Tax Credits (APTCs) and whose household income is under 150% of the federal poverty level (FPL), who would therefore qualify for a $0 premium benchmark plan under the American Rescue Plan Act. 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. This SEP will increase opportunities for enrollment, reduce the uninsured, and help minimize administrative burdens encountered by consumers trying to use existing SEPs.

Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

FEDERALLY FACILITATED MARKETPLACE USER FEE RATE § 156.50

The Marketplace user fee—a fixed percentage of premium revenue paid by insurers—supports critical functions, including operation of and improvements to the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. 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.

We support increasing the Marketplace user fee, slashed by the previous administration, which virtually ceased marketing and outreach and slashed funding for Navigators, core Marketplace functions funded by user fees. We encourage CMS to ensure the user fee rate is sufficient to support the critical functions it funds. The proposals in this rule will be successful only if they are supported by sufficient revenue for implementation. For example, extending Navigator roles to provide post-enrollment assistance and to provide assistance during the new monthly SEP for low-income people must be supported by Navigator grants that are adequate to support Navigator programs year-round.

SEGREGATION OF FUNDS FOR ABORTION SERVICES § 156.280

We support the proposal to rescind the never-implemented "double billing" rule, which would require issuers to send consumers one premium bill for abortion services and a separate premium bill for all other covered health care services, and instruct consumers to pay the separate bills in two separate transactions. The double billing rule would create consumer confusion, and because it could result in coverage being terminated if a consumer fails to pay both bills, we are concerned that it would lead to coverage losses. Rescinding the policy will reduce unnecessary administrative burdens on consumers and promote continuity of coverage.

Provisions of the Proposed Rule for Section 1332 Waivers - 31 CFR Part 33 and 45 CFR Part 155

Section 1332 Application Procedures—Statutory Guardrails 31 CFR 33.108(f)(3)(iv) and 45 CFR 155.1308(f)(3)(iv)

We strongly support the proposal to rescind the 1332 waiver guardrail interpretations announced in 2018 guidance and codified by the 2022 NBPP. We believe this approach will ensure consumers receive coverage that is as affordable and comprehensive under a 1332 waiver, consistent with the ACA.

Thank you for the opportunity to comment on these important proposals.

Sincerely,

Stacey Pogue
Senior Policy Analyst