



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

Submitted via Regulations.gov

December 23, 2020

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9914-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations," Proposed Rule.

Administrator Verma:

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, the co-chairs of the CCD Health Task Force, appreciate the opportunity to comment on this proposed rule.

Privatizing Marketplaces

We are very concerned about CMS's proposal to allow states to opt-out of providing a centralized enrollment website and instead require enrollees to use direct enrollment pathways operated by qualified health plan (QHP) issuers and web-brokers. 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. Privatizing the Marketplace not only harms consumers, it also contradicts the law. Allowing states to opt-out of using HealthCare.gov (or their own similar enrollment website) without a waiver clearly violates Affordable Care Act (ACA) requirements. Under the proposed rule, the state would provide a rudimentary website that displays basic plan information without a means to enroll, then direct people to private websites to complete the application. This violates the statutory requirement in section 1311(d)(2) of the ACA, which requires a

Marketplace to “make available qualified health plans to qualified individuals.” In general, individuals would not be able to enroll in QHPs through the state website.

CMS’s proposal also risks that substandard plans, such as short-term plans, would be presented alongside comprehensive insurance. Even now, brokers sometimes steer people into such plans, which often come with higher commissions, a tactic that has continued during the pandemic.¹ Brokers are reported to list non-compliant plans under headlines like “Obamacare Coverage”, clearly implying to customers that these plans meet the ACA protections with which people are now familiar.² Except the opposite is true; 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 potentially high out-of-pocket costs. For example, Kaiser Health News recently 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.³ The Government Accountability Office (GAO) recently released a study that revealed similar practices among agents and brokers.⁴ The public needs a one-stop-shop, conflict-free enrollment website, such as HealthCare.gov and current state Exchange websites.

Our coalition has been concerned about the expansion of short-term plans in the past few years. In 2018, we expressed concern with the proposal by the Departments of Treasury, Labor, and Health and Human Services to expand the length of coverage and renewability of SLTD plans.⁵ SLTD plans are not subject to consumer protections that have immense value for individuals with disabilities and chronic conditions, such as mandated essential health benefits, protections for people with pre-existing conditions, prohibitions on use of lifetime or annual caps, and other non-discrimination provisions. When the proposed rule was finalized, we issued another statement expressing our disappointment that the administration took action to expand a group of products that discriminate against people with disabilities and pre-existing conditions.⁶ We strongly oppose this new proposal that could steer even more people into these and other non-ACA-compliant plans.

¹ Christen Linke Young and Kathleen Hannick, “Misleading marketing of short-term health plans amid COVID-19,” Brookings Institution, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

² 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>

³ Government Accountability Office, PRIVATE HEALTH COVERAGE: Results of Covert Testing for Selected Offerings GAO-20-634R: Publicly Released: Sep 16, 2020. <https://khn.org/news/junk-insurance-plans-health-consumers-beware/>

⁴ <https://www.gao.gov/products/GAO-20-634R>

⁵ Coalition comments on Short-Term Limited Duration Insurance NPRM, April 23, 2018, http://c-c-d.org/fichiers/CCD-Comment-Letter_STLD-NPRM_FINAL_4-23-18.pdf

⁶ Coalition statement on Short-Term Limited Duration Insurance final rule, August 2, 2018, http://c-c-d.org/fichiers/statement-on-short-term-plan-final-rule-final_sy.pdf

Moreover, private brokers and insurers who operate through HealthCare.gov have a track record of failing to alert consumers of Medicaid eligibility and picking and choosing the plans they offer, often based on the size of plan commissions. In the system CMS is proposing, people who are eligible for Medicaid in states that no longer provide a single enrollment website could have a much harder time finding help with enrollment because Medicaid generally doesn't pay commissions and agents and brokers have no incentive to fill the gap left for this population that would result from eliminating HealthCare.gov.

Contrary to the promise of expanded choices, this proposal would rob consumers of their only option for a guaranteed, central source of unbiased information on the available comprehensive coverage. This would undoubtedly increase confusion about where and how to access good-quality health coverage, hindering enrollment and prompting many people to give up and become uninsured.

Codification of 1332 Guidance

We are very concerned with the proposal to incorporate guidance regarding 1332 waivers issued in 2018 into regulations.

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. Under the 2018 guidance, HHS and Treasury instead chose to consider the number of people who have *access* to affordable, comprehensive coverage, rather than the number who *enroll* in this coverage. This misinterpretation of the statutory guardrails will have real consequences for people with disabilities and chronic conditions, potentially steering people into substandard coverage, such as short-term, limited-duration plans and association health plans, which often do not cover the full range of benefits and services that people with disabilities rely on. As a result, people will find themselves with substandard coverage and encounter massive medical bills.

The ACA defines ten categories of Essential Health Benefits (EHBs), including habilitative and rehabilitative services and devices, emergency room services, and prescription drugs. Access to the EHBs is critical for people with disabilities. Under the 2018 guidance, states are able to design EHB benchmark plans that provide less generous coverage and yet still satisfy the coverage guardrail regarding comprehensiveness. People with disabilities and chronic conditions rely on coverage that includes EHBs to access the preventive services, medications, therapies, visits with primary care and specialist providers, and other benefits and services that they need to manage their day-to-day living. Allowing states to establish skimpier coverage requirements will seriously harm their health care and health outcomes.

Finally, the 2018 guidance does not include language from previous 1332 guidance that protects certain vulnerable populations, including older adults, individuals with low incomes, and those with or at risk of developing serious health issues. It also 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. People with disabilities and chronic conditions are much more likely to use their insurance and reach their out of pocket maximum. Changing these protections will disproportionately affect people with disabilities.

Finally, the proposed rule attempts to codify the 2018 guidance, for the most part, by reference rather than by crafting concrete regulatory language. Codifying this non-regulatory policy by reference is not only bad policy on the merits but is also legally dubious (as is the guidance itself, which deviates from the plain meaning of the statute). We urge CMS to withdraw this proposal.

Navigator and Certified Application Counselor Use of Web-Broker Websites

The NPRM proposes to allow assisters to use direct enrollment websites instead of HealthCare.gov or the state Exchange website to enroll consumers. We strongly oppose this proposal as it would make it more difficult for people with disabilities to get impartial assistance with the full range of coverage options available to them.

People with disabilities must consider numerous factors when selecting insurance coverage. Provider networks are critically important as people with disabilities often have relationships with specialists and other providers. They may have multiple medications and need affordable access to specific drugs due to contraindications. Therefore, it is critical that enrollment assisters provide impartial assistance to people with disabilities in selecting a plan. If an assister is using a website designed to steer people to enroll in certain plans, they are going have more challenges providing unbiased information about all of the coverage options available. In addition, using direct enrollment websites could lead to people who are eligible for Medicaid enrolling in a QHP instead because, as referenced above, these websites do not educate consumers about Medicaid or screen for eligibility as HealthCare.gov does.

CMS's stated reason for the proposal is that direct enrollment websites have innovative functionality that would be useful to assisters. Instead of further privatizing shopping for health insurance, CMS should further invest in HealthCare.gov to expand its functionality for assisters and consumers.

Enhanced Direct Enrollment Website Translations

The NPRM includes a proposal to allow QHP issuers and web-brokers participating in the FFE enhanced direct enrollment (EDE) program additional time to come into compliance with the website content translation requirements. We are concerned that

this proposal will lead to incomplete information for limited English proficient (LEP) consumers. CMS has not cited any evidence that this would in fact increase the number of QHP issuers in markets with a high number of LEP consumers. We think it is misguided to encourage participation in these markets by weakening language access requirements. We also note that the current 10% threshold for non-English languages spoken in a state⁷ is very high and certainly does not capture the language access needs of many LEP consumers. In fact, under this threshold, the only language that QHP issuers and web-brokers are required to translate website content into is Spanish, and no translations at all are required in most states. Therefore, we believe that this translation requirement is already inadequate and should not be weakened at the expense of LEP consumers.

In addition, while we appreciate that the additional time for compliance is limited to website content added as a condition of participation in the FFE EDE program, the proposed change nonetheless adds complexity and confusion. We are concerned that web brokers and QHP issuers would interpret the relaxed standard more broadly and not translate critical information such as SBCs or provider directories. We would likewise be concerned that these same brokers and issuers may interpret this flexibility to include non-compliance with website accessibility standards,⁸ further impeding access for people with disabilities.

Finally, as a threshold matter, we generally oppose this and other measures aimed at promoting and expanding direct enrollment options. EDE, which allows web-brokers and QHPs to direct shoppers to completely bypass HealthCare.gov or the state Exchange, already steers consumers with fewer health care needs into higher deductible and even non-ACA compliant plans. Layering on lower standards for language access for EDE will likely increase “cherry-picking” as LEP populations tend to have poorer health due to discrimination and unmet care needs,⁹ which harms consumers with disabilities and higher health care needs by affecting the risk pool and increasing premiums.

Premium Adjustment Percentage and Maximum Out-of-Pocket Costs

As we expressed in 2019,¹⁰ we are very concerned about the change to the calculation of the Premium Adjustment Percentage that results in such drastically increased costs for individuals and families. For 2022, CMS calculates the annual out-of-pocket limit to be \$9,100 for individuals and \$18,200 for families. We urge CMS to return to the

⁷ 45 C.F.R. 155.205(c)(2)(iv)

⁸ 45 C.F.R. 155.205(c)(1)

⁹ Green, Alexander and Chijioke Nze, "Language-Based Inequity in Health Care: Who Is the “Poor Historian”?" *AMA Journal of Ethics*, March 2017, <https://journalofethics.ama-assn.org/article/language-based-inequity-health-care-who-poor-historian/2017-03>. 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>.

¹⁰ Coalition comments on Notice of Benefit and Payment Parameters for 2020, February 19, 2019, http://c-c-d.org/fichiers/NBPP_comments.pdf

methodology first used for the 2015 plan year and lower these figures and protect people from unaffordable costs. The impact of the change to the premium adjustment percentage has particularly harmed people with disabilities and chronic conditions who are more likely to reach the maximum.

Essential Health Benefits

Essential Health Benefits (EHB) are absolutely crucial for ensuring that people with disabilities have access to needed healthcare services. This coalition has consistently commented^{11,12, 13} on the need for a strong federal definition of essential health benefits, especially habilitative and rehabilitative services. Early in ACA implementation, CMS set out a regulatory framework that set EHBs based on benchmark plans available in that state. For plan year 2020 CMS changed policy regarding state selection of EHB-benchmark plans, newly allowing states to select a benchmark from other states, substituting one or more EHB categories from a benchmark plan in another state, or otherwise selecting a set of benefits to become the state's EHB benchmark plan. We strongly objected to this change.¹⁴

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 are concerned that allowing benchmarking across state lines, or abandoning benchmarking entirely, can create a "race to the bottom" in defining EHBs, encouraging states to select a more limited benefit package than they would otherwise offer. This could especially affect rehabilitative and habilitative services and devices, mental health and substance use services, prescription drugs, and other crucial disability-related health care services. By granting States expansive power to alter their EHB benchmark plans so dramatically every year, the Proposed Rule threatens any hope of predictability of coverage for consumers from year-to-year and State-to-State. This will likely reduce quality of care and increase downstream costs due to a lack of predictability in coverage of these essential services and devices. We urge CMS to return to its previous benchmarking policy.

Network Adequacy

This proposed rule includes a proposal regarding non-application of network adequacy standards to QHPs that do not maintain a network. We do not have a comment on this

¹¹ Coalition letter to Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight, December 23, 2012. [http://c-c-d.org/fichiers/CCD_Comments_on_EHB_Proposed_Rule\(D0454783\).pdf](http://c-c-d.org/fichiers/CCD_Comments_on_EHB_Proposed_Rule(D0454783).pdf)

¹² Coalition comments on Notice of Benefit and Payment Parameters for 2016, December 22, 2014, <http://c-c-d.org/fichiers/CCD-Health-Task-Force-Final-Comments-on-NBPP-2016.pdf>

¹³ Coalition comments on Notice of Benefit and Payment Parameters for 2017, December 21, 2015, <http://c-c-d.org/fichiers/CCD-health-comments-2017-benefit-and-payment-parameters--one-12-21-15final.pdf>

¹⁴ Coalition comments on Notice of Benefit and Payment Parameters for 2019, November 27, 2017, <http://c-c-d.org/fichiers/CCD-Response-to-Benefit-and-Payment-Parameters-Rule-2017-final.pdf>

proposal. However, we would like to take this opportunity to re-iterate some of our long-standing concerns regarding network adequacy.

Our coalition has strongly supported strong federal network adequacy standards. Robust provider networks are particularly important for people with disabilities and chronic conditions. For plan year 2019, CMS weakened federal standards and instead gave states a larger role in the QHP certification process, including regarding network adequacy.

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 of inpatient and/or outpatient settings.

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

Special Enrollment Period Verification

The proposed rule would require State-based Exchanges (SBEs) to conduct eligibility verification for at least 75 percent of new enrollments through Special Enrollment Periods (SEPs) for consumers who were not already enrolled in Exchange coverage. We are concerned with this change, as these documentation requirements can be burdensome for many consumers and inhibit legitimate enrollment.

We are especially concerned that CMS is considering enacting 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. We 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.

ESI Verification, SEP COBRA, Ability to change plans if newly ineligible for APTC

The proposed rule includes flexibility on verification of eligibility for ESI and the creation of a SEP for those who have lost financial support from their former employer for COBRA premiums. We support these provisions.

We also support the proposal to allow QHP enrollees who lose APTC eligibility to enroll in a QHP of a lower metal level. This will promote continuity of coverage by allowing consumers who can no longer afford their premium without APTC assistance to enroll in a plan with a lower premium.

Reducing the User Fee

The proposed rule would cut the federal marketplace user fee by 25 percent, from 3 percent to 2.25 percent and would cut the user fee for state-based marketplaces that use the federal platform from 2.5 percent to 1.75 percent. We disagree with this proposal because 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.

The proposed rule's rationale for the cut is that the lower user fee would be sufficient to fund current marketplace activities. But current activities are inadequate. Under the current Administration, CMS has virtually ceased marketing and outreach and has slashed funding for Navigators, core marketplace functions funded by user fees. Rather than cutting the user fee, it should be increased to 3.5 percent (the level in effect prior to 2020) to restore outreach and enrollment assistance programs and to fund continued improvements to HealthCare.gov, including technological enhancements and improved customer service.

Thank you for the opportunity to comment on this important regulation. For more information, please contact Rachel Patterson at rpatterson@efa.org or Natalie Kean at nkean@justiceinaging.org.

Sincerely,

The CCD Health Task Force Co-chairs:
Natalie Kean, Justice in Aging
Dave Machledt, National Health Law Program
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