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July 28, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicaid and Medicaid Services
Department of Health and Human Services
Attention: CMS–9906–P
PO Box 8016
Baltimore, MD 21244-8016

Submitted Electronically via www.regulations.gov

RE: [CMS-9906-P] Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to provide comments on the proposals included in the "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule." As a state-based public policy organization in Minnesota, Center of the American Experiment has a particular interest in how this rule will impact a state's flexibility to address unique challenges facing its insurance markets under the Patient Protection and Affordable Care Act (ACA). Overall, we hold strong concerns that the proposed rule will substantially limit state flexibility, harm insurance market risk pools, and result in higher, less affordable premiums.

Navigator Program Standards

The ACA requires an Exchange to establish a Navigator program.[1] At a minimum, the ACA requires a Navigator to perform five duties: conduct public education activities on the availability of qualified health plans (QHPs); distribute fair and impartial information on enrollment in QHPs and the availability of premium and cost sharing subsidies; facilitate enrollment in QHPs; provide referrals for enrollees with a grievance, complaint, or question regarding their health plan or coverage; and provide information in a manner that is culturally

[1] PPACA § 1311(d)(4)(K).

and linguistically appropriate for the population served by the Exchange.[2] On top of these statutory duties, CMS proposes to reinstitute a requirement that Navigators in the Federally-facilitated Exchanges (FFEs) provide information and assistance with regard to certain post-enrollment topics. We oppose this policy change because it would add an unnecessary requirement on Navigators when they already struggle to perform their basic statutory duties, and would put consumers at higher risk of receiving poor information.

Adds an Unnecessary, Counterproductive Requirement

In the 2020 Payment Notice, CMS removed requirements on Navigators to provide certain post-enrollment assistance and, instead, made this assistance optional.[3] At the time, CMS recognized this post-enrollment assistance was not among the Navigator duties required in statute.[4] While CMS originally put this requirement in place to strengthen consumer assistance, CMS concluded the requirement added an unnecessary regulatory burden on Navigators that ultimately limited their flexibility to design a program that best meets the needs of consumers.

The Navigator program has been a controversial element of the ACA. Agents and brokers have complained that Navigators are basically a free government competitor that crowds out their services and fails to deliver the same level of service consumers need to truly navigate the insurance market.[5] Navigators have also been criticized as being less about health care and more about supporting a progressive political infrastructure to build influence.[6]

In addition, since the Exchange began operations, Navigators have struggled to perform their core statutory duty to facilitate enrollment in QHPs. Data from CMS show Navigators have historically enrolled only a tiny portion of consumers through the FFE, responsible for just 83,495 FFE enrollments for plan year 2017 (less than one percent of plan selections for the 2017 OEP) even with $63 million in funding.[7] This level of performance created legitimate questions over how Navigators were using federal funding.

Considering ongoing concerns over the appropriate role and effectiveness of Navigators, CMS should exercise careful oversight over the Navigator program to ensure Navigators are effectively meeting their core statutory duties before CMS adds new non-core duties. Without any evidence that Navigators are adequately meeting their statutory duties, it would be

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[2] PPACA § 1311(i)(3).
[3] 84 FR 17454, April 25, 2019, available at https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.
[4] Id. at 17512.
[5] Nicholas Kusnetz, "Obamacare's Hidden Battle: Insurance Agents Push State Regulation of Guides to New Marketplaces," *The Center for Public Integrity*, August 9, 2013, at https://publicintegrity.org/politics/state-politics/obamacares-hidden-battle-insurance-agents-push-state-regulation-of-guides-to-new-marketplaces/.
[6] "Obama's Acorn Cronies To Profit From Obamacare," *Investor's Business Daily*, October 2, 2013, available at https://www.investors.com/politics/policy-analysis/obama-acorn-pals-cashing-in-on-obamacare/.
[7] Centers for Medicare & Medicaid Services, Navigator Funding and Enrollment Data, PY 2016-2020, at https://www.cms.gov/files/document/2016-2020-navigator-funding-and-enrollment-data.xlsx (January 19, 2021). These data may underreport Navigator enrollments to a degree because HealthCare.gov could not accommodate including both a Navigator and an agent or broker as a referral. However, this likely had only a minimal impact. The issue was addressed in subsequent OEPs and there was no appreciable upswing in Navigator referrals after the change.

counterproductive to add additional duties at this time. Maintaining post-enrollment assistance as an option helps ensure Navigators can focus on meeting their statutory duties.

Maintaining post-enrollment assistance as an option also provides important flexibility on how Navigators allocate federal resources to carry out their statutory duties. For example, under current rules Navigators in communities with robust post-enrollment assistance through other avenues may reasonably decide to focus their resources upfront on enrollment assistance. Other Navigators may find post-enrollment assistance lacking in their communities and determine they are best positioned to fill this need. Current regulations give Navigators the flexibility to determine how best to serve their communities and consumers. Reinstituting post-enrollment assistance as a requirement would undermine this flexibility.

Moving forward, we recommend that CMS increases oversight over Navigators to ensure they are effectively performing their core statutory duties, especially in light of the substantial boost in funding recently announced.

Puts Consumers at Risk

The proposed requirement to provide post-enrollment assistance puts consumers at risk of receiving poor information from a Navigator. The statute requires Navigators to provide referrals "for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage."[8] While CMS cites to this duty as evidence suggesting Congress anticipated the need for post-enrollment assistance from Navigators, the statutory provision is more appropriately read to suggest that Congress understood the limited expertise of a Navigator.

By requiring Navigators to provide assistance beyond a referral, the requirement would put enrollees at risk of receiving poor information from a Navigator who has no professional expertise or capacity to properly address the issue. For instance, while regulations restrict Navigators from providing tax assistance or advice, a requirement on all Navigators to provide information on taxes would substantially increase the risk that a consumer inappropriately receives tax advice. Navigators already stretched to meet their statutory duties may not appreciate the sometimes subtle difference between connecting people with information and providing advice.

Recognizing this risk, a requirement to provide post-enrollment assistance may in fact conflict with the statutory duty to provide referrals. By requiring referrals, Congress showed a clear intent to connect consumers with experts when they experienced certain issues. A requirement on Navigators to provide the same type of assistance will encourage Navigators to stand in the place of these experts and undermines the congressional intent to connect consumers with expert advice in these circumstances.

[8] PPACA § 1311(i)(3)(D).

Exchange Direct Enrollment Option

Earlier this year, CMS finalized regulations to facilitate the Exchange Direct Enrollment option (Exchange DE option) in Part 1 of the 2022 Payment Notice, which provides a process for states to pursue a new Exchange model that takes better advantage of private sector entities to enroll people through the Exchange.[9] CMS now proposes to repeal the Exchange DE option, citing recent shifts in policy goals, new federal laws, lack of state interest, and a potential misalignment with administration priorities. Because the Exchange DE option offers a significant opportunity for states to improve the consumer enrollment experience through the Exchange, we oppose this proposal.

A Promising New Exchange Model

The ACA provides states with substantial flexibility in how they design and implement Exchanges. However, most states refused to implement Exchanges on their own and resorted to the federal default which offered only limited options. As the FFE platform has evolved, new opportunities emerged to give states more opportunities. In particular, the introduction of Enhanced Direct Enrollment (EDE) allowed the private sector to operate websites that provided all the consumer services necessary to enroll someone in an individual market QHP offered through the Exchange and access premium tax credits if they're eligible. This evolution finally ushered in an Exchange vision that so many people talked about at the time the ACA passed—a vision of enrollment websites like Expedia or Travelocity and, importantly, a vision of competing Exchange enrollment websites driven to deliver a better consumer experience.

When CMS finalized the Exchange DE option, it noted several disadvantages to CMS operating a centralized, singular Exchange-operated website like HealthCare.gov. A single Exchange-operated website can be costly and burdensome to create and operate. A single Exchange enrollment pathway tends to create enrollment chokepoints that can impose challenges and even failures when large number of consumers come to enroll at the same time, such as the final day of the OEP. Finally, it's more difficult for a single Exchange-operated website to keep up with the rapid pace of technological innovation.

Instead of states relying on a single Exchange-operated website, the Exchange DE option provides a regulatory process for states to adopt an Exchange model through which consumers can enroll in coverage through the FFE platform via multiple and competing private-sector websites. The Exchange DE option also formalizes a process to help State Based Exchanges (SBEs) adopt a similar Exchange model. This Exchange model meets all the statutory and regulatory requirements for operating an Exchange.

Advantages of the Exchange DE Option

The Exchange DE option provides states with a number of key advantages over the traditional Exchange. First, it builds off the substantial success of EDE, which is proving to be an attractive enrollment option that delivers a better consumer experience. In only its second full year of operation, the EDE pathway doubled enrollments during the 2021 OEP, increasing from from 521,000 to 1,130,000.[10] Moreover, the EDE pathway attracted a higher proportion of new

[9] 86 FR 6138, January 19, 2021, available at https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022.
[10] Centers for Medicare & Medicaid Services, "Impact of Enhanced Direct Enrollment During

consumers. This demonstrates the importance and effectiveness of private sector incentives to bringing in new enrollments, which are critical to maintaining a healthy risk pool. EDE also increased the portion of consumers who made active plan selections, another key indicator of how the private sector more effectively engages consumers.

Understanding the benefits that EDE brings, the Exchange DE option strengthens these benefits by creating stronger incentives for the private sector to participate in EDE. Since Exchanges were launched in 2014, the single Exchange-operated website model has crowded out the private sector. By removing the dominant public sector competitor, the Exchange DE option makes EDE the primary enrollment platform and draws in more EDE competitors to drive a better consumer experience.

No justification for repeal

With these clear advantages, recent changes to policy and operation priorities do not justify the wholesale repeal of the Exchange DE option. Every new administration will bring in a new set of priorities and redirect resources to those priorities. CMS cited the passage of the American Rescue Plan Act (ARPA) and the need to implement its new grant program for Exchange modernization and temporary expansion of premium tax credits as key policy changes that justify repealing the Exchange DE option. In light of the substantial work necessary to implement ARPA, it's entirely understandable to focus resources on that important work right now.

However, it is not reasonable to use ARPA as a pretense for the wholesale repeal of the Exchange DE option. To justify repealing the Exchange DE option, the proposed rule relies largely on the need "[t]o foreclose the possibility that federal funding and resources will be diverted from efforts to provide direct benefits to consumers made available under recent legislation to optional programs."[11] Yet this need is temporary. The ARPA provisions expire at the end of 2022 and, therefore, CMS will be able to transition back to normal operations. To protect federal resources from being diverted to optional programs, CMS could easily delay the effective date of the Exchange DE option.

Aligns with Executive Orders

CMS also cites the priority to carry out Executive Orders 14009 and 13895 as reason to repeal the Exchange DE option. Yet, aside from the need to focus resources on implementing ARPA, the Exchange DE option aligns quite well with these executive orders. Consistent with EO 13985, as CMS explained earlier this year, "the Exchange DE option holds potential to better connect vulnerable populations to coverage than a centralized one-size-fits-all Exchange model."[12] The private sector has proven to be very capable at connecting with new people and there is every reason to believe that, with the right incentives in place, the private sector would quickly develop new and better outreach programs for vulnerable populations.

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the Open Enrollment Period for 2021 Coverage," CCIIO Data Brief Series (January 2021), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-EDE-OEP-2021-Coverage.pdf.

[11] 86 FR 35167.

[12] 86 FR 6151.

Consistent with both sections 1 and 3 of EO 14009, EDE has proven to be possibly the most effective policy to protect and strengthen the ACA. Time and again, prior implementation decisions undermined the strength of the ACA regulated insurance markets. As a recent CMS report on affordability explained, certain ACA implementation decisions led to higher premiums and kept healthier people out of the risk pool, including "decisions on Exchange implementation, the allowance of transitional policies, and the lack of Exchange verification of eligibility for special enrollment periods."[13]

In contrast, EDE brought the private sector back and re-introduced the powerful competitive dynamics a strong market needs to flourish. As noted previously, recent experience shows EDE brings more new people and spurs more active consumer engagement. Making EDE the primary enrollment platform would only serve to strengthen the ACA regulated markets and, importantly, better connect the millions of people eligible for subsidies under the ACA but remain uninsured.

Repeal Can Only Weaken the ACA
Ultimately, the wholesale repeal of the Exchange DE option can only serve to weaken the ACA. Repealing the Exchange DE option will entirely foreclose the opportunity for a state to come forward with an Exchange model that would strengthen the ACA-regulated market. The Exchange DE option is strictly permissive for states and it is entirely at the discretion of CMS to approve or deny a state's proposal. There is no cost to maintaining the DE option aside from the resources necessary to review a state proposal. CMS is, therefore, making the determination that the resources necessary to review a state proposal outweighs the possibility a proposal could deliver better results and strengthen the ACA over the status quo.

In other words, by repealing the Exchange DE option, CMS is prejudging every possible state proposal without ever seeing it and throwing away the possibility that a proposal could strengthen the ACA.

Open Enrollment Period Extension
Under policies set by the Obama Administration, the annual open enrollment period (OEP) was shortened to run from November 1 to December 15 beginning for plan years starting January 1, 2019 and beyond.[14] The Market Stabilization Rule issued in April 2017 under the Trump administration advanced this change to begin for plan years starting January 1, 2018 and beyond.[15] CMS now proposes to extend the OEP by another four weeks to run from November 1 to January 15 of the following year. We oppose this proposal because the extension of the OEP would unnecessarily increase the risk of adverse selection and, therefore, weaken the ACA.

[13] Centers for Medicare & Medicaid Services, "Affordability in the Marketplaces remains an issue for Moderate Income Americans," CCIIO Data Brief Series (January 2021), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf.
[14] 81 FR 12206, March 8, 2016 available at https://www.federalregister.gov/documents/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017.
[15] 82 FR 18346, April 18, 2017, available at https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization.

Current OEP Benefits Consumers, Strengthens Market
In the proposed rule, CMS outlined a number of strong reasons why maintaining the current OEP would benefit consumers and strengthen the market. The current OEP ensures consumers receive a full year of coverage and simplifies operational processes for issuers and Exchanges. Further, a consistent OEP promotes consumer confidence. CMS noted how the current OEP improved the consumer experience, citing observations that casework volumes related to coverage start dates and inadvertent dual enrollment decreased. CMS also explained how moving back to January 15 could cause consumer confusion about the need to enroll by December 15 for January 1 coverage and cause some consumers to miss coverage for January. Finally, CMS noted the adverse selection issue without discussion and only stated they "do not anticipate a significant impact on the Exchange risk pool." All of the reasons outlined by CMS weigh in favor of maintaining the current OEP.

Negative Impacts of Current OEP are Minimal
The primary rationale CMS cites for extending the OEP by a full month is to help consumers who may unknowingly auto re-enroll into a plan with unexpected cost increases. This could occur if an enrollee happens to live an area where the premium for the benchmark plan declined and, consequently, reduced the value of the enrollee's premium tax credit. CMS cites no evidence that this is a widespread problem or a significant burden when it happens. As premiums have held steady over the past three years, the negative impact is likely minimal.

Negative Impacts Easily Mitigated
People already receive notices in September and October, including the Marketplace Open Enrollment Notice (MOEN) and issuer generated notices.[16] While the MOEN alerts consumers that they need to update their information for purposes of calculating APTC, issuer notices provide financial assistance amounts and identifies the re-enrollment plan for the upcoming plan year. To the extent people miss these notices and are uninformed or receive incomplete or inaccurate information in these notices, improved noticing offers a far better solution to mitigate this issue. Moreover, as noted in the EDE discussion, the expansion of EDE is encouraging more people to actively review their plan which increasingly mitigates this issue as EDE expands.

CMS also noted the concerns of Navigators, CACs, and agents and brokers regarding people not having enough time to fully assist people during the OEP. However, CMS presented no evidence that more time to enroll will actually help. Assisters and brokers and agents will always have issues due to people waiting until the last minute. Changing when that last minute happens does not solve this problem. A better option is to implement policies to encourage people to sign up for coverage in November and not wait until the last minute.

[16] Centers for Medicare & Medicaid Services, "Notices," at https://marketplace.cms.gov/applications-and-forms/notices; see also Centers for Medicare & Medicaid Services, Marketplace Open Enrollment Notices and Outreach File for Enrollees at Risk of Losing Financial Assistance, September 30, 2019, available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2012232553-jp-ab_slides_preparing_py2021_oe_092420_5cr_100620.pdf.

Adverse Selection Warrants Further Review

Adverse selection warrants much more thorough consideration by CMS. There is clear evidence of people timing coverage and taking advantage of enrollment periods. Adding another month to the OEP gives people more opportunities to time coverage. After CMS implemented a shorter OEP and tightened SEPs through the Market Stabilization Rule, enrollees were more likely to maintain continuous coverage.[17] If there were no issue with adverse selection, employer-based health plans and Medicare would likely offer longer OEPs. Before further consideration of extending the OEP, we recommend that CMS undertake a much more rigorous analysis and subject that analysis to further public comment.

In sum, on balance, the positive impacts of maintaining a 6-week OEP far outweigh the negative impacts outlined by CMS. To the extent negative impacts exist, enhanced consumer engagement is the answer.

Monthly Special Enrollment Period for Low-Income APTC-eligible

In addition to extending the OEP, CMS also proposes to create a monthly special enrollment for people with incomes lower than 150 percent of the federal poverty line (FPL). This would allow eligible people at that income level to enroll at any time they want during the year. CMS's main argument for proposing this policy is a response to the temporary availability of enhanced premium tax credits that subsidize the full premium for a silver-level plan under the ARPA. CMS worries that some consumers who qualify for these free premium plans will continue to forgo enrolling due to a lack of awareness. We oppose this policy because it is entirely unnecessary, would weaken the ACA by increasing adverse selection, and would violate both the text and spirit of the ACA.

Unnecessary

While CMS expressed concerns about people missing the chance to enroll in premium-free plans, there are multiple opportunities in place right now for people to enroll in these plans. People with incomes under 150 percent already qualify for the COVID SEP and can immediately take advantage of zero-premium plans without a new SEP until August 15. Thus, people at this income level will have had 6 months since ARPA became law to become informed and sign up for a zero-premium plan. After the SEP ends, people newly eligible for premium subsidies will also have access to an SEP.

CMS argues, even with ARPA, some consumers will continue to forgo coverage. But this is true for any benefit and therefore does not provide justification for the proposed changes. By this logic, there should be no rules on enrollment around any government benefit as there will always be a portion of people who lack awareness of the rules and fail to enroll.

[17] See Centers for Medicare & Medicaid Services, Fact Sheet, "Effectuated Enrollment for the First Half of 2019," December 11, 2019, at https://www.cms.gov/newsroom/fact-sheets/effectuated-enrollment-first-half-2019 (finding effectuated enrollments for June 2019 as a percent of plan selections for the 2019 benefit year were up from the previous year).

Increases Adverse Selection

CMS acknowledges the SEP would increase adverse selection. The agency estimates this adverse selection would increase premiums for consumers by 0.5 to 2.0 percent. CMS notes "there is no limitation on how often individuals who are eligible for this special enrollment period can obtain or utilize it."[18] Therefore, individuals would be free to jump in and out of health plans as often as they want. In addition, it is likely such an open-ended SEP coupled with the lengthy and sometimes burdensome enrollment process provided by HealthCare.gov would cause many healthy enrollees to wait until they get sick to enroll in coverage.

Adverse selection has been a serious problem under the ACA's guaranteed availability requirements. Actuaries have consistently identified the ACA's community rating and guaranteed availability requirements as leading contributors to the substantial increase in premiums that occurred after the ACA's main regulations to effect in 2014. Enrollment periods are one of the few tools to mitigate this negative impact of the ACA.

Rules to tighten enrollment periods proved successful. After the CMS finalized the Market Stabilization Rule and additional SEP policies in the 2019 payment notice, premiums stabilized and insurers gained confidence to reenter ACA markets.

Any move to loosen these restrictions risks turning back the gains made to strengthen the ACA's market over the past few years. This would clearly be inconsistent with EO 14009's directive to strengthen the ACA. Considering there is no clear need or advantage to this SEP, there is no reasonable justification to revert to looser SEP requirements.

Violates the Statute

The ACA allows insurance companies in the individual market to restrict enrollment to open enrollment or special enrollment periods.[19] It further requires insurers to, at a minimum, establish the special enrollment periods for qualifying life events that apply to group health plans.[20] In regards to the Exchange, the ACA also requires HHS to establish an initial open enrollment, an annual open enrollment period, the same special enrollment periods that apply to group health plans under the IRS Code, other special enrollment periods similar to circumstances for periods identified for Medicare Part D enrollment, and special monthly enrollment periods for Indians.[21]

Based on the prescriptive nature of how the statute itemizes a list of required enrollment periods for Exchanges, the statute limits CMS from requiring additional enrollment periods that are not included in the list. This reading naturally follows the interpretative canon *expressio unius est exclusion alterius* (the inclusion of one is the exclusion of the other).

The ACA includes various provisions that impose a list of requirements on the Secretary, which then give the Secretary discretion to add to the list. For instance, the same section of the ACA includes a requirement on health plans to submit specific information on transparency in

[18] 86 FR 35169.
[19] PPACA § 2702(b)(1).
[20] PPACA § 2702(b)(2).
[21] PPACA § 1311(c)(6).

coverage to the Secretary and the last item on the list provides for "Other information as determined appropriate by the Secretary."[22] The list of required enrollment periods does not include any similar language giving the Secretary discretion to add to the list. To the extent discretion is allowed it is based on the Secretary's discretion to define an SEP itemized in the list, such as the meaning of "exceptional circumstance."

The proposed monthly SEP does not fit within any SEP itemized in statute and, therefore, the statute limits CMS from requiring this monthly SEP. The inclusion of one monthly enrollment period for Indians on the list provides further evidence that Congress meant to exclude any other monthly enrollment period. Congress likely understood the importance of enrollment periods to the overall structure and stability of the ACA and how they functioned as one of the few checks against adverse selection. Therefore, it makes sense how Congress chose to limit the Secretary's discretion to add enrollment periods that risk undermining the risk pool.

User Fee Rates

CMS reduced the Exchange user fee rate from 3.5 percent to 3.0 percent for the 2020 and 2021 benefit years[23] and then reduced the fee to 2.25 percent for the 2022 benefit year.[24] CMS now proposes to increase the user fee to 2.75 percent to help fund the additional costs of expanded services, including increased funding for the Navigator program and consumer outreach and education. We oppose increasing the user fee because any increase will result in higher premiums, excess collections from prior years would cover the cost of expanded services, and reversing CMS's strategy to draw down excess collections likely violates federal law and regulation.

Increases premiums, reduces affordability

Because insurers are required to adjust the premium index rate based on the Exchange user fee, prior reductions in the Exchange user fee translated into a direct reduction in premium for consumers.[25] Likewise, any increase in the user fee will translate into higher premiums. As this action will undoubtedly make health coverage less affordable for some people, this proposal clearly contravenes EO 14009's directive to make healthcare affordable for every American.

People with incomes too high to qualify for subsidies were exposed to dramatic premium increases after the ACA's main regulations took effect. According to CMS, average monthly premiums increased from $242 in 2013 to $352 in 2014 and reached $588 by 2018—a 143 percent increase.[26] While premiums finally stabilized in 2019, premiums remain unaffordable

[22] PPACA § 1311(e)(3)(A)(ix).
[23] 84 FR 17454, April 25, 2019, available at https://www.federalregister.gov/documents/2019/04/25/2019-08017/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2020.
[24] 86 FR 6138, January 19, 2021, available at https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022.
[25] 85 CFR 78572, 78631, December 4, 2020, available at https://www.federalregister.gov/documents/2020/12/04/2020-26534/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and.
[26] Centers for Medicare & Medicaid Services, "The Unsubsidized Uninsured: The Impact of Premium Affordability on Insurance Coverage," CCIIO Data Brief Series (January 2021), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uninsured-Affordability-in-Marketplace.pdf.

for people who don't qualify for subsidies. Higher premiums also impose additional burdens on Federal taxpayers. Due to the affordability crisis in the individual market, there is simply no reasonable justification to take deliberate steps that would result in higher premiums.

Excess Collections Can Cover Additional Costs

Earlier this year CMS committed to increase funding for the Navigator program, as well as consumer outreach and education. This boost in funding was not necessary based on prior experience. As previously noted, Navigators historically failed to enroll enough people to justify the funding levels they received. Moreover, funding on outreach was never clearly shown to impact enrollment much. Enrollment actually dropped on HealthCare.gov after CMS boosted outreach funding from $51 million to $100 million for the 2017 OEP.[27]

Regardless of the wisdom of this funding increase, it cannot justify an increase in the user fee because excess collections from prior years would fully cover this additional cost. The user fee was previously lowered due to a number of factors, including the accumulation of "prior years' additional collections."[28] The proposal to raise the user fee completely disregards this important factor guiding previous decisions by CMS to lower the user fee. As such, the proposal provides no evidence that this excess in collections from prior years is not sufficient to support the lower user fee.

Even without excess collections from prior years, an increase in user fee collections in 2021 and 2022 due to increased enrollment from ARPA's expanded premium subsidies would likely fully fund these additional costs. Effectuated enrollment showed an increase of 6 percent in February 2021 compared to the prior year and projects even more enrollment with expansion of premium tax credits under ARPA.[29] Just a 6 percent increase in enrollment would increase user fee revenues by possibly $75 million. Without any contrary evidence from CMS, this increase in user fee collections can be assumed to fund a majority if not the entire increase in funding for Navigators and outreach and education.

Reversing Strategy to Draw Down Excess Collections May Violate Law

Prior CMS rulemaking took responsibility for excess collections from prior years and CMS has a duty to spend the excess collections on eligible user fee expenses. As explained in the 2020 payment notice, "any collections in excess of user fee eligible costs for a given year are rolled over for spending to the subsequent year's user fee eligible expenses."[30]

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[27] Seema Verma, "Thank Obamacare for the Rise of the Uninsured," *Centers for Medicare & Medicaid Services Blog*, September 13, 2019, available at https://wayback.archive-it.org/2744/20201231212644/https://www.cms.gov/blog/thank-obamacare-rise-uninsured.

[28] 86 CFR 6138, 6170, available at https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-01175.pdf. As explained in the 2020 payment notice, "any collections in excess of user fee eligible costs for a given year are rolled over for spending to the subsequent year's user fee eligible expenses." 84 CFR , 17532, available at https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08017.pdf. And as noted in part 1 of the 2022 payment notice final rule, "[b]ased on *prior years' additional collections* and future projected changes in costs, enrollment, and premiums, we project that HHS can fully fund Federal [Exchange] platform costs … .[emphasis added]" Id., at 6171.

[29] Centers for Medicare & Medicaid Services, *Effectuated Enrollment: Early 2021 Snapshot and Full Year 2020 Average*, June 5, 2021, available at https://www.cms.gov/document/Early-2021-2020-Effectuated-Enrollment-Report.pdf.

[30] 84 FR 17532.

Allowing the user fee to accumulate from year to year without proper adjustment to account for excess collections would effectively constitute a charge in excess of the "Full Cost" to the federal government in violation of section 6(a)(2) of OMB Circular A-25. The legal implications of an excess charge are not entirely clear, but there are limits on the federal government's power to collect user fees. Maintaining excess collections from year to year and doing nothing to ensure collections are carefully spent on user-fee eligible expenses would likely violate legal requirements around the administration of a user fee.

Section 1332 Waivers

In December 2015, CMS issued controversial guidance on 1332 waivers which, as two writers for the *Health Affairs blog* explained, "considerably limits [State] flexibility."[31] CMS and the Department of the Treasury (the Departments) issued updated guidance in October 2018,[32] which replaced the 2015 guidance[33] to give states significantly more flexibility. In January 2021, the Departments then codified much of the policy included in the 2018 guidance into regulatory provisions related to 1332 waivers.[34] The Departments now propose to remove the recent codification of the 2018 guidance after determining that it is generally inconsistent with EO 14009 and EO 13985. The Departments also propose new policies and applications of the statute that they state "aligns with the Administration's goals to strengthen the ACA and increase enrollment in comprehensive, affordable coverage among the remaining underinsured and insured."[35] We oppose this substantial shift in policy because it would eviscerate states' flexibility to innovate and implement new state health programs, and ultimately fail to accomplish the goals the Departments hope to achieve.

Eviscerates State Flexibility to Innovate

As just noted, the Departments issued guidance in 2018 to replace the 2015 guidance that was broadly understood to severely limit a state's flexibility. When adopting the 2018 guidance, the Departments cited how "[t]he 2015 guidance imposed significant restrictions on states in meeting the guardrails beyond what was required by the PPACA."[36] The proposed rule would reverse the flexibility provided in 2018 and revert once again to imposing significant restrictions on states that go well beyond what the ACA requires.

Section 1332 of the ACA allows states to waive a number of the ACA's key provisions, such as requirements to cover essential health benefits, establish Exchanges, and provide premium tax credits. These and other requirements can be waived so long as the state program meets additional statutory requirements, often called guardrails. In general, the guardrails require a

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[31] Heather Howard and Dan Meuse, "New Section 1332 Guidance A Mixed Bag For States," *Health Affairs Blog*, February 29, 2016, at https://www.healthaffairs.org/do/10.1377/hblog20160229.053456/full/.
[32] 83 FR 53575, October 24, 2018, available at https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers.
[33] 80 FR 78131, December 16, 2015, available at https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation.
[34] 86 FR 6138, January 19, 2021, available at https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022.
[35] 86 FR 35181.
[36] Centers for Medicare & Medicaid Services, Fact Sheet, "State Relief and Empowerment Waiver Guidance," October 22, 2018, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SRE-Waiver-Fact-Sheet.pdf.

state plan to provide coverage that is at least as *comprehensive* and *affordable* as coverage without the waiver, provide coverage to *comparable number* of people as without the waiver, and *not increase the federal deficit*.

While the proposal claims "it would empower states to develop innovative health coverage options … that best fits the states' individual needs and provide coverage to their residents,"[37] in practice the rule would basically limit states to developing waivers that mirror the ACA. It does this by applying the guardrails in a manner that forces a state waiver to ensure individuals *are enrolled* in at least the same level of comprehensive and affordable coverage as the ACA already requires. In contrast, current federal regulations require a state waiver to ensure individuals have *access* to the same comprehensive and affordable coverage as available without the waiver under ACA requirements.

This access standard gives states meaningful flexibility to expand the types of coverage options a state waiver can provide. So long as the waiver provides access to the same level of comprehensiveness and affordability as the ACA requires without a waiver, a state can provide access to other types of coverage that don't meet these ACA requirements. For instance, this would include allowing coverage that provides lower premiums, but that does not meet the ACA's cost sharing requirements. The proposed rule would eliminate this flexibility.

In addition to severely limiting flexibility under the comprehensiveness and affordability guardrails, the proposed rule would also reduce the flexibility in meeting the coverage guardrail be narrowing the type of coverage that can be counted.

Changes Would Undermine Congressional Intent
To justify the proposed changes, the Departments conclude the 2018 Guidance and the incorporation of its guardrail interpretations into regulation "do not represent the best fulfillment of congressional intent behind the statutory guardrails."[38] This statement is made without any rationale, which is remarkable considering Part 1 of the 2022 Payment Notice included a thorough explanation as to how the 2018 Guidance is "based on a sound interpretation of section 1332 of the PPACA" and follows the plain language of the statute.[39]

Congress intended to give states a meaningful level of flexibility to develop and implement innovative new state health programs. The 1332 waiver represents Congress's recognition that states have always played the primary role in regulating insurance and administering public health care programs. Moreover, several provisions in the ACA specifically assert Congress's general intent to maintain the state's primary role.[40]

A review of the plain language reveals that Congress clearly did not intend to establish guardrails that require people to enroll in plans that meet the same affordability and comprehensiveness requirements as the ACA. Yet, as noted, the proposed regulations would basically allow a waiver from the requirements of the ACA only so long as the waiver meets the requirements of

[37] 86 FR 35181.
[38] 86 FR 35185.
[39] 86 FR 6162.
[40] See e.g., PPACA §§ 1312(d)(2); 1321(b) and (d); and 1563(c)(13)(A) and (14)(A).

the ACA. This is made very clear in the way CMS critiques current regulations for allowing consumers to enroll in "plans that do not fully meet ACA requirements."[41]

It defies any rational basis to conclude Congress intended to allow states to waive certain requirements of the ACA so long as the state waiver fully meets the waived ACA requirements. But that is exactly what the Departments are proposing. Section 1332 clearly allows states to waive the ACA's essential health benefit requirements under section 1302(b). Yet, the proposal would require a state waiver plan to ensure people actually enroll in plans that meet the requirements of 1302(b). In addition, section 1332 clearly allows states to waive cost sharing limits in section 1302(c) and actuarial value (AV) levels established in 1302(d). Yet to meet the affordability guardrail, the proposal would require a state waiver plan to ensure people actually enroll in "coverage that provides both an actuarial value equal to or greater than 60 percent and an out-of-pocket maximum that complies with section 1302(c)(1) of the ACA."[42]

Congress could not have intended this outcome when they included the flexibility for states to waive these ACA requirements. It simply makes no sense that Congress intended to allow a state to waive certain requirements outlined in Section 1332 only to then require the state waiver plan to meet those same requirements under the statutory guardrails.

By contrast, the *access* standard delivers the most sensible interpretation of congressional intent because it gives meaning to the full text of the statute. Specifically, the access standard gives meaning to the guardrails requirement that a waiver must provide coverage that is "at least as comprehensive as the coverage defined in section 1302(b) and, at the same time, gives meaning to the flexibility to apply for a waiver from the requirements of section 1302(b).

Guardrail Application Could be Made More Consistent

The proposed rule notes how some commenters find the current regulation "allows for a disjointed application of the guardrails whereby a state can meet the coverage guardrail, while its waiver plan reduces the overall comprehensiveness and affordability of coverage in the state." While maybe not disjointed, the application of the three guardrails is not consistent and may not provide the full flexibility that Congress intended. Each of these three guardrails begin with the direction that a state waiver plan "will *provide*". For the comprehensiveness and affordability guardrails, the preamble to Part 1 of the 2022 payment notice notes the term "provide" means "to supply or make available" and this plain language strongly supports the access standard.[43] This access standard, however, is not applied in the same way to the coverage guardrail despite the use of the same language.

To maintain consistency, CMS could consider also applying the access standard to the coverage guardrail. This application would give states more flexibility to consider waivers that provide access to coverage to at least a comparable number of residents without requiring the same number of residents to actually purchase coverage. However, it's unlikely any state would actually pursue a waiver that forecasted a drop in the number of covered people and offsetting increase in the number of uninsured.

[41] 86 FR 35184.
[42] 86 FR 35187.
[43] 86 FR 6162.

Current Flexibility Would Not Diminish Affordability of Comprehensive Plans
The flexibility introduced under the access standard has regularly met unfair criticism from people who claim the allowance of alternative coverage options could undermine the individual market risk pool for comprehensive coverage and make this coverage less affordable for people with pre-existing conditions. Maybe it's just unclear drafting, but CMS now appears to endorse the view that this flexibility creates the possibility of "diminished affordability of comprehensive coverage."[44] This is flatly wrong and directly contravenes the clear statement from Part 1 of the 2022 Payment Notice which states, "consistent with the 2018 Guidance, that the Departments will consider the comprehensiveness and affordability guardrails met if a waiver plan provides access to coverage that is as comprehensive and affordable as coverage forecasted to have been available in the absence of the waiver."[45] Since issuing the 2018 guidance, CMS has consistently explained that any waiver that diminishes the affordability of comprehensive coverage cannot be approved and would fail to meet the guardrails.

Decreases Choice and Opportunity for Vulnerable Populations
The proposed rule noted concerns that alternative plan options can terminate or deny coverage based on health status and created the possibility that individuals with greater health needs might go without effective coverage. Yet, the Departments never acknowledge that these individuals would always have access to the same level of affordable and comprehensive coverage as without the waiver. The harm, apparently, is providing people a choice. Vulnerable populations might choose poorly.

This ignores how waiver flexibility might allow states to better tailor plans for people with greater health needs. A waiver might also target benefits or even subsidies to certain vulnerable populations. The proposed rule would shut down any state flexibility to develop plans that might strike a different balance between comprehensiveness and specific needs of vulnerable populations. In this way it would decrease choice and opportunity for these vulnerable populations and undermine the goals set out in EO 13985.

Ignores Tradeoffs
Shutting down the flexibility for states to strike a different balance between comprehensiveness and specific needs of vulnerable populations reflects a more widespread weakness of the proposed rule. Throughout, the rule fails to acknowledge the existence of tradeoffs—in particular, tradeoffs between policies that promote comprehensiveness versus affordability. More comprehensive policies tend to be less affordable and vice versa. The 2018 guidance recognized these tradeoffs and further recognized states and individuals are in a better position to make these tradeoffs than the federal government. Without acknowledging tradeoffs, the Departments are in a real sense failing to acknowledge the fundamental problems facing America's health care system.

Weakens the ACA
The provision of Section 1332 State Innovation Waivers is an incredibly important feature built into the ACA. These waivers recognize there may be better ways to structure a state health plan than the requirements Congress set to paper in 2010. Waivers give states the opportunity to

[44] 86 FR 35183.
[45] 86 FR 6158.

explore and test out innovative approaches to achieve better outcomes than may be possible under the strictures of the ACA. By creating this opportunity for states to achieve better outcomes, this opportunity to waive the ACA's requirements in a real sense strengthens the ACA.

By eviscerating the flexibility Congress intended to give states, the proposed rule would clearly weaken the ACA by substantially diminishing the opportunities for states to innovate health plans that could achieve better outcomes.

Thank you for your consideration of these comments.

Sincerely,

/S/

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