

March 7, 2017

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*National Advocates for
Asian American,
Native Hawaiian &
Pacific Islander Health*

Dr. Patrick Conway, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9929-P
P.O. Box 8016, Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; Market Stabilization Proposed Rule

Dear Dr. Conway,

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to provide comments on the February 17th proposed rule, Patient Protection and Affordable Care Act; Market Stabilization, docket number CMS-9929-P. We are writing to express our deep concerns about multiple provisions in the proposed rule that would reduce access to healthcare for consumers, several of which may have a disproportionate impact on minority and immigrant populations. In addition, the proposals, if adopted, would lead to instability in the marketplace.

We oppose formalizing restrictions on consumers applying for special enrollment periods (SEPs), such as requiring documentation, preventing changing metal tiers or requiring proof of continuous coverage, that will suppress health coverage levels. Our comments focus on the disparate negative impact that shortening open enrollment would have and urge the Centers for Medicare & Medicaid (CMS) to maintain its current length. We also oppose proposals to allow greater de minimis variation in actuarial value, increasing consumer cost sharing and reducing the value of premium tax credits. We additionally oppose requiring consumers to back-pay missed premium payments before enrolling in coverage, a proposal that violates the ACA's promise of guaranteed renewability of coverage. Finally, we ask CMS to maintain network adequacy standards, and not void federal protections in favor of potentially weaker state rules or reducing requirements for plans to include essential community providers.

With more than 30 community-based organizational (CBO) partners in over 20 states and territories, APIAHF provides a voice in the nation's capital for Asian American (AA), Native Hawaiian and Pacific Islander (NHPI) communities, who comprise the fastest growing racial and ethnic groups in the country. APIAHF works toward health equity and health justice for all communities, from Arizona to Washington. Since 2012, APIAHF and partners have worked to enroll nearly 1 million consumers through [Action for Health Justice \(AHJ\)](#), a national collaborative of more than 70 AA and NHPI national and local community-based organizations and health centers. We have seen how the ACA has had an important impact on reducing AA and NHPI health disparities. Since the law's passage, the percent of uninsured AAs has dropped from 15.1 percent in 2010 to 7.5 percent in 2015. For NHPis, that drop was 14.5 percent in

2010 to 7.8 percent in 2015.¹ Considering our experience, we are concerned that this proposed rule has the potential to reduce those gains.

Through Action for Health Justice, assisters and navigators have seen firsthand the challenges that AA and NHPI and limited English proficient consumers face in enrolling in coverage, including not accessing critical enrollment information or not understanding steps needed to verify eligibility. One in three AAs are limited English proficient (LEP), defined by the U.S. Census as “speaking English less than very well.” Over the course of four enrollment periods, Action for Health Justice assisters and navigators have seen firsthand the challenges that LEP consumers face in enrolling in coverage, including not accessing critical enrollment information or additional steps needed to verify eligibility. As described in the report, *Improving the Road to ACA Coverage, Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities*,² over the course of four open enrollment periods APIAHF and national partners documented the significant barriers AA & NHPI populations have faced in enrolling in healthcare.²

Among those who spoke languages other than English at home, AAs (31.4%) have an LEP rate almost four times higher than the rate for Non-Hispanic Whites (6.0%) and the total U.S. population (8.6%). Among AA ethnic groups, Bhutanese (78.3%) have the highest proportion of adults with LEP, followed by Burmese (70.2%), Nepalese (51.5%), Vietnamese (49.2%), and Bangladeshis (44.2%). There are a significant number of NHPI ethnic groups who also have high proportions of LEP such as Marshallese (45.4%) Fijians (20.2%) and Tongans (17.2%).

Because AAs and NHPIs represent a diverse group with many different languages and cultures, these populations faced unique challenges related to language, immigration status, and health literacy as they attempted to enroll in coverage. The Action for Health Justice report identified a deficit in resources from state and federal policymakers for LEP consumers that, while improved, continues today. Many provisions in this proposed rule would exacerbate negative experiences for AA and NHPI consumers in accessing health coverage and undermine the marketplace.

I. Special Enrollment Periods (SEP) (\$155.420)

As the proposed rule notes, SEPs are used to ensure that people who lose coverage during the year or experience a qualifying event are able to enroll in new coverage or make changes to their coverage. SEPs thus promote continuity of coverage, a key component of a healthy marketplace.

We are concerned however, that as proposed, adding a new requirement of pre-enrollment verification will restrict—not promote—consumers’ ability to get health insurance through an SEP. As such, we urge CMS to not include these restrictions in the final rule. Special enrollment periods were included in the ACA as a way to ensure people undergoing life changes are able to easily secure health coverage. No verifiable evidence has shown that ineligible people are enrolling via SEPs, yet, according to the Urban Institute, only 5 percent of SEP-eligible consumers enrolled in 2015.³ The proposed changes to the SEP eligibility

¹ APIAHF analysis of American Community Survey data.

² *Improving the Road to ACA Coverage. Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities*. Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | AAJC, and Asian Americans Advancing Justice | Los Angeles. (2014).

www.apiahf.org/sites/default/files/2014.10.14_Improving%20the%20Road%20to%20ACA%20Coverage_National%20Report.pdf

³ Stan Dorn. *Helping Special Enrollment Periods Work under the Affordable Care Act*. (June 2016),

<http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>.

determination process do not reflect the ACA's goals, and instead, CMS should do more outreach to promote the availability of SEPs.

We are deeply concerned that CMS is proposing to require 100 percent of SEP enrollees to provide documentation verifying their SEP eligibility. Requiring burdensome documentation and adding additional steps to the enrollment process creates barriers and disincentives for consumers. Instead, we urge CMS to continue the existing self-attestation policy. CMS' pilot of pre-enrollment verification in 2016 led to a "20 percent reduction in the number of consumers enrolling through special enrollment periods, compared to 2015, with every week since the implementation of the confirmation process in 2016 showing lower enrollment than the corresponding week in 2015."⁴ CMS also noted only 55 percent of consumers age 18-24 completed the verification process after outreach while 73 percent of consumers age 55 to 64 did. Such data indicate that requiring verification worsens the risk pool by discouraging enrollment of younger, healthier populations, rather than improving it.

We highlight the story of Stephenie Lai of Rome, Georgia, who was able to get healthcare because of an SEP. In 2015, Stephenie turned 26 outside of an open enrollment and was able to enroll in exchange coverage using an SEP when she lost access to her parent's insurance. Almost immediately after, Stephenie was diagnosed with Hodgkin's Lymphoma. If Stephenie had faced barriers to enrollment, she might have been forced to wait before getting cancer treatment. Stephenie's story demonstrates that SEPs play a critical role in the ACA's expansion of coverage and restricting access to coverage while verifying eligibility may mean consumers in need of treatment would be forced to forgo it.

a. Pre-enrollment verification would hinder enrollment by immigrants and LEP persons

Experience has also shown that complex verification processes have a disproportionate impact on immigrant populations. During routine open enrollment, some immigrant families have had to wait months to verify their status, due to inability to verify their identity or eligibility for financial assistance. We expect that immigrants will face similar problems under these proposed rules, and may face extended delays in accessing coverage. Immigrants frequently travel for work, such as seasonal or migrant workers, and as such may lack documentation that proves residence because they lack a fixed address. Additionally, because some municipalities are hostile to immigrant populations suspected of lacking documentation, some families may be unable to request a birth certificate for citizen children born in the United States, thus affecting their ability to enroll in coverage. For example, until a lawsuit was recently settled, some babies born in Texas to parents unable to provide specific documents were not issued birth certificates.⁵ We have also heard reports from our Action for Health Justice partners that immigrants with lawful status are increasingly reluctant to share information with the government.

In addition, pre-enrollment verification may also have a disproportionate impact on persons who speak limited English and may not understand how to respond to verification requests. During previous enrollment periods, LEP consumers have faced long call times, challenges with the quality of language services offered by the call center and overall confusion about how to proceed with enrollment. Currently, CMS does not translate marketplace notices and relies on consumers to work with enrollment assisters or the call center to determine the content of messages they receive from the marketplace. Requiring LEP consumers to submit to additional documents to verify SEP eligibility will compound this barrier for those

⁴ *Pre-Enrollment Verification for Special Enrollment Periods*. Centers for Medicare and Medicaid Services. (December 12, 2016). <https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf>.

⁵ Julia Preston. *Lawsuit Forces Texas to Make it Easier for Immigrants to Get Birth Certificates for Children*. New York Times. (July 23, 2016). <https://www.nytimes.com/2016/07/25/us/lawsuit-texas-immigrants-birth-certificates.html>

unable to understand the request, comply within the proposed 30-day period or lack the resources or language capacity to respond.

b. If the proposed verification is adopted, CMS should implement a pilot program

Should CMS finalize the proposed pre-enrollment verification for SEPs, we urge you to set aside a comparison group as you request comment on in the proposed rule. Creating such a group would allow CMS to verify, as intended in the pilot program finalized in the 2018 Notice of Benefit and Payment Parameters, whether such steps improve or worsen the risk pool. In particular, we urge CMS to make the pilot large enough, including, if necessary, over-samples of smaller populations, to determine whether requiring documentation deters enrollment from eligible immigrants, LEP individuals and among racial and ethnic minorities.

c. If the proposed verification is adopted, CMS should develop specific turnaround periods for verification.

We also urge CMS, if it finalizes the proposed rule as written, to commit to specific turnaround periods for verification. Under the proposed rule, consumers have 30 days after enrolling in an SEP to provide verification documents. However, the rule provides no guidance for when verification must be approved by the agency. For consumers with complex cases, verification may take a significant time. In the proposed rule, CMS recommends that consumers who experience delays in verification may no longer request a later coverage late beyond one month later than their original effective date. If CMS is unable to ensure that eligibility can be verified in a specific, short period of time, we urge it to not go forward with this proposal to limit consumer's ability to back date effective dates. Consumers waiting for verification will experience uncertainty and be less likely to utilize healthcare services, and may become responsible for paying premiums for months of coverage they did not utilize.

Additionally, we urge CMS to ensure that verification systems allow consumers to track their submitted documents verifying SEP eligibility, confirm that the documents have been received and are being processed and receive clear information as to whether the documents are deemed acceptable or need revisions. Allowing consumers to track the status of these documents ensures they are engaged in the process and are not left in uncertainty.

If CMS requires verification of SEP eligibility, we also urge CMS to engage in comprehensive outreach efforts, including working with community organizations that understand the needs of AAs and NHPs, LEP and immigrant consumers. If consumers do not submit verification documents, CMS should follow up extensively, including in the preferred written language of the consumer. CMS should also provide training and guidance for enrollment workers who will need to provide assistance to consumers with complex cases.

d. The proposal limiting metal tiers is not justified by evidence

We are also concerned that the proposed rule would prevent consumers from changing plan metal tiers when enrolling in an SEP. As the proposed rule states, this would differ from the rules governing group markets. Such a difference is not justified. When consumers undergo a life change, such as marrying a spouse or gaining a child with different health conditions than themselves, it is reasonable to expect that their health care needs might change. In addition, losing a job would lower income, impacting the amount of health insurance a consumer may find affordable. In the proposed rule, CMS states that there are concerns that consumers are using SEPs to change metal tiers based on ongoing health needs. Because the

circumstances leading to an SEP often involve dramatic life changes and would be unlikely to occur solely for the sake of changing one's metal tier of health insurance, CMS should provide evidence to back up these concerns. As such, we oppose limiting consumers' ability to upgrade the metal coverage of their plan.

e. State exchanges should maintain flexibility in SEPs

CMS asks whether State Based Marketplaces (SBMs) should be permitted flexibility to allow consumers to go through the verification process. We believe states should be able to address their own population's needs, which may vary in terms of consumers' use of SEPs. Issuers operating in SBMs may have different experiences with consumers who enroll in an SEP and may not require these new onerous processes. Generally, states have been allowed to govern their own SEP process. We urge CMS to allow states running their own exchanges to maintain that role.

f. A continuous coverage requirement is not supported by the ACA

In the preamble to this rule, CMS asks for comment on a variety of other measures to encourage continuous coverage. The preamble considers requiring individuals applying for SEPs to show prior coverage of health insurance in order to enroll. CMS also suggests that consumers who do not maintain continuous coverage, but wish to enroll in an SEP could face a lockout period or a fee. We find these ideas very troubling, highlight that they are not supported by statute, and oppose any proposal to create a continuous coverage requirement in regulation or statute.

Section 2702 of the ACA, Guaranteed Availability of Coverage states that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." No exception is provided for requiring continuity of coverage in an SEP. In addition, the law specifically establishes which incentives Congress believed were necessary to encourage consumers to obtain health insurance, such as the individual mandate, the open enrollment for those who are not eligible for an SEP, and its affordability provisions. Requiring continuous coverage to enroll in an SEP, or punishing the lack thereof, is inconsistent with the ACA.

II. Open Enrollment Periods (§155.410)

Under the proposed rule, the coverage year 2018 open enrollment period would be cut in half, from November 1, 2017 - January 31, 2018 to November 1, 2017 - December 15, 2017. We strongly oppose reducing the open enrollment period and urge CMS to maintain the previously finalized dates. Reducing the open enrollment period from three months to six weeks would substantially hinder the robust enrollment that is needed to sustain the marketplaces and further deter enrollment from the communities that require the most outreach, namely healthy, younger people and immigrant and community of color populations.

a. A shorter open enrollment period will result in less young people enrolling

CMS has stated it wishes to improve coverage risk pools with the goal of reducing health insurance premiums. Yet, it has been widely documented that younger people enroll later in the period and require more education about the importance of health insurance. One report quotes Richard Frank, the then Assistant Secretary of Planning and Evaluation, on the growth of younger people in the 2016 coverage year open enrollment. He stated that increases in enrollment of younger people is a, "very good sign for the health and the stability of the marketplace' because young people tend to wait to sign up until the end of

open enrollment.”⁶ Former Healthcare.gov CEO Kevin Counihan said, when commercials promoting enrollment were cancelled in the most recent open enrollment, “We know that more young people enroll during the final days of open enrollment, but they need to be reminded of the Jan. 31 deadline.”⁷ Condensing the open enrollment period reduces the time during which young adults are most likely to enroll.

b. A reduced open enrollment period would affect LEP consumers and those with complex needs, requiring enhanced and consistent outreach by CMS

We also have learned from experience that minority communities and consumers with complex situations, who are more likely to be a part of a vulnerable community, enroll later, in particular because of the extensive efforts required to reach them, often by community organizations. According to our analysis of CMS’s enrollment snapshots, for the fourth open enrollment period, in federally facilitated exchanges, 30 percent of calls to the call center occurred after January 1st compared to 5 percent of plan selections (or 16 percent of new plan consumers). In the third open enrollment period, we identify a similar trend: 11 percent of plan selections were made after January, compared with 34 percent of call center contacts. While the enrollment snapshots did not include data on all LEP consumers, the number of consumers who needed assistance in Spanish was even higher. For OE4 38 percent of all calls with a Spanish speaking representative occurred after January 1st. In OE3, that rate was 41 percent.⁸

In addition, consumers are distracted towards the end of the year, and many may miss information on open enrollment. Research shows that decision making capacity is stretched during this time of year, and consumers may not be able to make decisions on issues as complex as health insurance, instead opting to not decide at all.⁹ Additionally, the Urban Institute reports that financial pressures are highest on consumers in December, when their debt peaks.¹⁰ They may make a decision that they cannot afford insurance or buy a less robust plan than truly meets their healthcare needs than they would at a different time in the year.

If CMS finalizes the proposed shortened enrollment period, we urge it to engage in at least equal outreach and enrollment efforts as previous enrollment periods. In the proposed rule CMS, says it “would intend to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame.” We urge CMS to maintain the same level of investment and resources put into these outreach efforts and request it provide more details about its outreach efforts in a final rule.

In particular, we urge CMS to include robust resources targeted to enrolling LEP consumers. We appreciate CMS’ work to improve the in-language materials it has, as well as the quality of call center interpretation services. In order to mitigate the impact the shortened open enrollment will have on LEP consumers, CMS

⁶ Melissa Attias. *Young Adult Health Law Enrollment Touted by HHS*. CQ Rollcall. (January 7, 2016).

<http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2016/jan/jan-11-2016/young-adult-health-law-enrollment-touted-by-hhs>

⁷ *Trump administration pulls back on healthcare.gov ads*. Associated Press. (January 27, 2017).

<http://www.cbsnews.com/news/trump-administration-pulls-back-on-healthcare-gov-ads/>

⁸ APIAHF analysis of biweekly (for OE4) and weekly (OE3) CMS enrollment snapshot reports.

⁹ Katherine Swartz and John A. Graves. *Shifting The Open Enrollment Period For ACA Marketplaces Could Increase Enrollment And Improve Plan Choices*. Health Affairs. (June 2014).

<http://content.healthaffairs.org/content/early/2014/06/20/hlthaff.2014.0007>

¹⁰ Stan Dorn. *Enrollment Periods in 2015 and Beyond*. Urban Institute (February 2015).

<http://www.urban.org/sites/default/files/publication/41616/2000104-Enrollment-Periods-in-2015-and-Beyond.pdf>

should dedicate the same level of investment it would dedicate to LEP enrollment in a three month enrollment period to the six week period and in addition, conduct outreach in non-English languages.

Additionally, we appreciate that CMS has directed navigator funding towards community groups with experience working with diverse communities. We urge CMS to maintain at least current levels of navigator funding and to direct grants towards CBOs with experience enrolling LEP and AA and NHPI populations in health insurance. Doing otherwise will result in even greater disparities in enrollment than otherwise might occur. These groups have a unique ability to connect with consumers and communities that are not met elsewhere, but we wish to express concern that they will have greater difficulty in achieving their best potential in a restricted time period even with static funding.

III. Levels of Coverage (Actuarial Value) (\$156.140)

This proposed rule would modify the allowed de minimis variation in actuarial value (AV) to permit an additional negative two points from each plan metal tier. The metal tiers were an important inclusion in the ACA to help consumers differentiate between how plans fit their personal healthcare needs, particularly in terms of cost sharing. We oppose reducing the actuarial value, which would shift costs from issuers to consumers, as CMS acknowledges in the cost benefit analysis section of the proposed rule. The likelihood of such a change providing any better value for consumers is low, however, as lower premiums will be accompanied by higher cost sharing requirements.

Analysis has shown that the impact on consumers likely would discourage enrollment and reduce the affordability of insurance. Families USA found that reducing the AV of a silver plan from 68 percent to 66 percent could increase deductibles by over \$1000.¹¹ Consumers have already expressed frustration with high deductibles in health plans and reporting has covered the stories of those who are going without care because they cannot afford to cover their costs pre-deductible.¹²

Additionally, the Center on Budget and Policy Priorities has identified that the lower-value silver plans allowed under the rule would in turn, lower the value of premium tax credits.¹³ Consumers who receive tax credits could be forced to choose between paying more for their same insurance or pay the same for lower quality coverage. Some may choose to forfeit insurance altogether. This scenario does not apply to consumers who receive cost sharing reduction subsidies and we urge CMS to ensure that remains the case, though the impact on consumers who have incomes too high for cost sharing subsidies is concerning.

Consumers also rely on the metal tiers to differentiate between the value and cost sharing required among different products. Increasing the variation, particularly to allow lower value plans, blurs the lines between metal tiers, and may lead to consumers unwittingly enrolling in a plan that does not meet their needs.

We urge CMS to maintain the current allowable de minimis variation of -2/+2 percent. A two percent variation is clearly within the boundaries of de minimis, as allowed by the ACA statute, while stretching it to -4/+2 necessarily raises questions as to what is allowable under law. CMS should avoid such questions that could add further uncertainty into the market. We concur with Families USA and the Center on Budget and Policy Priorities that if CMS insists on implementing such a change, that it only apply to bronze

¹¹ Lydia Mitts, Caitlin Morris, and Liz Hagan, *President Trump's Proposed ACA Changes Favor Health Issuers at Consumers' Expense*. Families USA. (February 15, 2017). <http://familiesusa.org/blog/2017/02/president-trump-proposed-aca-changes-favor-health-issuers-consumer-expense>

¹² See for example Washington, DC: Families USA,; Laura Ungar and Jayne O'Donnell. *Dilemma over deductibles: Costs crippling middle class*. USA Today. (2015). <http://www.usatoday.com/story/news/nation/2015/01/01/middle-class-workers-struggle-to-pay-for-care-despite-insurance/19841235/>

¹³

level plans. If the goal is to attract consumers who care solely about premiums, and not cost sharing, allowing lower AV on the lowest spectrum of plans would achieve that goal.

IV. Guaranteed Availability of Coverage (§147.104)

We oppose the sections of the proposed rule that would allow issuers to refuse coverage to a consumer who owes the issuer unpaid premiums from the previous 12 months. Low-income consumers may have to make decisions between putting food on the table or paying their bills. Putting those consumers into a circumstance where they may be denied coverage returns the country to the time where periods of income instability threatened consumers' access to health insurance.

When passing the ACA, Congress was clear that the law's goal was to ensure income was not a barrier to healthcare. For example, in casting her vote in favor of the bill, Representative Linda Sanchez said "There is no reason that hard working Americans should be priced out of needed healthcare."¹⁴ Representative Sanford Bishop stated, "I believe that we have a moral obligation to ensure that all Americans, regardless of race, ethnicity, geography, or income, receive the health care they need to lead healthy and productive lives."¹⁵ Even more specifically, Section 2703 of the Affordable Care Act, Guaranteed Renewability of Coverage states, "If a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable." This proposal does not align with that text, which does not create any exemption for nonpayment of premiums.

Families may miss premium payments for many reasons, as incomes fluctuate and they have to choose between buying groceries or paying health insurance premiums. The ACA was meant to, as indicated by members voting for its passage and its text, ensure income was no longer a barrier to healthcare. Under this proposal, if a family was terminated from coverage for missing premiums and wishes to re-enroll, they must gather up to three months of premiums, in addition to paying premiums for their new coverage. If combined with the proposal to shorten open enrollment, this would exacerbate the end of year economic tightness faced by families and discussed earlier in these comments. For families with incomes below the 20th percentile, Asian Americans had over \$1000 less in savings than Whites. Such families may find themselves comparably less able to pay this lump sum.¹⁶

If CMS continues ahead with this proposal, significant consumer outreach is needed by the federal government and issuers. Consumers should be notified when signing up for coverage that they will have to repay premiums if they miss payments and wish to re-enroll with the same carrier. If a consumer misses a payment, issuers must be required to send a notice to consumers of the consequences of missing the payment and informing the consumer of their option to cancel their coverage. At the end of the grace period, consumer should receive a notice informing them of their options from the marketplace. All of these notices should be sent to consumers in their preferred language.

We agree that issuers should be able to accept less than 100 percent of payment as full payment for these purposes, should CMS finalize the rule as proposed. Consumers may well be able to pay some, but not all

¹⁴ 156 Cong. Rec. H1891-01, 2010 WL 1027566. Congressional Record --- House of Representatives. Proceedings and Debates of the 111th Congress, Second Session. (Sunday, March 21, 2010). Page 21.

¹⁵ 156 Cong. Rec. H1891-01, 2010 WL 1027566. Congressional Record --- House of Representatives. Proceedings and Debates of the 111th Congress, Second Session. (Sunday, March 21, 2010). Page 51.

¹⁶ Christian E. Weller and Jeffrey Thompson. *Wealth Inequality Among Asian Americans Greater Than Among Whites*. Center for American Progress. (June 20th, 2016). <https://www.americanprogress.org/issues/race/reports/2016/12/20/295359/wealth-inequality-among-asian-americans-greater-than-among-whites/>

of past premiums, which should not be a barrier to coverage. Consumers should be given clear language notifying them of this option, including in their preferred language.

We also appreciate that CMS reminds issuers, though in a footnote, that they may not discriminate in how they apply any of these provisions. Section 1557, among other civil rights protections, ensures that issuers must evenly apply their standards without regards to sex, age, race or national origin, which includes preferred language. We encourage CMS to continue to emphasize these protections and ensure proper enforcement.

V. Network Adequacy (§156.230) and Essential Community Providers (§156.235)

Diverse populations, such as AAs & NHPs, benefit from a diversity of providers to choose for their healthcare. For some populations, finding a culturally competent doctor or one that can communicate in their language is one of the most important aspects of ensuring good health. Yet this proposed rule would roll back existing consumer protections that help to promote robust provider networks without providing any clear benefit, as the only savings would come from marginal administrative costs for issuers with little likely impact on premiums. We urge CMS to look to how it might encourage stronger networks instead of implementing provisions that would weaken consumer access.

The proposed rule would negate federal network adequacy standards in states that have some level of their own standards. We disagree that states, who may have weaker standards, should gain a renewed role as described in the rule. Federal network adequacy laws should be the floor from which states can improve upon. Consumers deserve the peace of mind of knowing they have a choice of qualified providers no matter where they live.

In states that do not have network adequacy standards (only 21 states had quantitative standards in 2014),¹⁷ the federal government would revert to its 2014 standards of relying on an issuer's accreditation from an accreditation entity. This is an unfortunate step back and we urge CMS not to abandon the progress it has made on promoting network adequacy.

In addition, we urge CMS to not adopt its proposal to allow issuers to have only 20 percent, rather than 30 percent, of an area's essential community providers (ECPs) as part of its network. Essential Community Providers, such as Federally Qualified Health Centers (FQHCs) and safety-net hospitals play a critical role in providing healthcare to AA & NHP populations by delivering care that is culturally and linguistically accessible. Over 800,000 AAs and 200,000 NHPs rely on health centers to receive quality, reliable care.¹⁸

Issuers should be making a strong effort to include FQHCs, and, as has been previously recommended in comments by the Association of Asian Pacific Community Health Organizations and the National Association of Community Health Centers, QHPs should be required to offer good faith contracts to all FQHCs in their service area.

Reducing the percentage of ECPs required within each QHP would result in consumers losing their provider of choice and having to find a new provider, disrupting treatment and care plans. Because these providers are often staffed by the communities they serve, losing their provider of a choice would mean more than

¹⁷ Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks*. Georgetown Center for Health Insurance Reform. (May 2015). http://www.commonwealthfund.org/~media/files/publications/issuebrief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

¹⁸ *2015 Health Center Data*. Health Resources Services Administration. (2015). <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2015&state>

just finding a different doctor for consumers from immigrant or communities of color, but also losing a doctor who understands their cultural background.

VI. Comment Period Length

We wish to express our deep concerns about the unusually short comment period for this rule, as compared to the typical 30 or 60-day comment window. While we understand CMS' desire to provide a level of certainty for the market, we believe this 20-day period provides insufficient time for detailed analysis of the proposed rule's impact. In particular, given that this rule may have a disparate impact on communities of color, LEP populations and immigrants, more time would have allowed for a more in depth analysis with data and research of how the proposals would impact those groups. We request that CMS take additional steps to communicate with and receive feedback from impacted groups.

Thank you for the opportunity to comment on this proposed rule. Please do not hesitate to contact Amina Ferati, Senior Director of Government Relations & Policy (afferati@apiahf.org) or Ben D'Avanzo, Senior Policy Analyst (bdavanzo@apiahf.org) if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kathy Ko Chin', with a long horizontal line extending to the right.

Kathy Ko Chin

President & CEO

Asian & Pacific Islander American Health Forum