

February 19, 2019

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

Seema Verma, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

**Re: RIN 0938–AT37 HHS Notice of Benefit and Payment Parameters for 2020**

Dear Administrator Verma:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks you for the opportunity to comment on the Notice of Benefit and Payment Parameters for 2020. We wish to express our concern about several areas that could negatively impact the communities we work with, while noting a few proposals that we agree will serve the needs of consumers.

With more than 150 community-based organization (CBO) partners in 28 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 outreach to, educate and enroll 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.<sup>1</sup>

Overall, we urge CMS to take actions that would increase the number of consumers enrolled in Affordable Care Act (ACA) compliant plans. 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 6.5 percent in 2016. For NHPIs, that drop was from 14.5 percent in 2010 to 7.7 percent in 2016.<sup>2</sup> However, we are concerned that for the first time since the law's passage, in 2017, the uninsured rate for AAs was stagnant at 6.4 percent, while the rate for NHPIs worryingly increased to 8.3 percent. We believe that some aspects of this proposed rule will further this trend and undermine access to coverage.

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<sup>1</sup> Action for Health Justice was co-founded by the Asian & Pacific Islander American Health Forum, Association of Asian and Pacific Community Health Organizations, Asian Americans Advancing Justice-AAJC and Asian Americans Advancing Justice--LA.

<sup>2</sup> APIAHF analysis of 2010 and 2016 American Community Survey 1-year estimates.

**I. § 155.210 navigator program standards and § 155.215 standards applicable to navigators and non-navigator assistance personnel**

In the 2019 Notice of Benefit and Payment Parameters, and previous two funding opportunities for navigators, CMS has taken steps to undermine the ability of consumers to access in-person assistance. As a result of CMS cuts to the navigator program, consumers have far fewer trusted organizations and individuals to turn to for help enrolling in qualified health coverage. We remain concerned that the policies adopted under the 2019 Notice opens the door for navigator entities that are not focused on a consumer's best interest and those that have little connection to the communities they are funded to serve.

In the 2020 Notice, CMS proposes that the additional post-open enrollment duties for navigators that it made required topics two years ago would now be made optional. We oppose this change and urge CMS not to adopt this proposal. The proposed rule justifies the change as "this change would allow FFE navigators working with fewer resources to continue prioritizing providing help to consumers who are seeking to apply for and enroll in coverage over other permissible duties." We note, however, that FFE navigators have fewer resources because CMS *itself* has made the decision to significantly cut the navigator program over the past two years.

The overall need of consumers for year-round assistance has not changed since CMS adopted the current policy of requiring navigators to engage in post-open enrollment activities. For example, in November of 2018 a Kaiser Family Foundation poll found that only one-third of consumers were aware that Congress has zeroed out the penalty for not having insurance.<sup>3</sup> Similarly, large numbers were unable to correctly name the date open enrollment ends. If navigator entities were getting the resources they need to fully serve their communities, they would not be facing as difficult decisions about trading off how to serve their clients. Instead of reducing the required duties for navigator programs, CMS should restore funding to at least the funding level received in the plan year 2017 open enrollment period.

***Assistance after open enrollment has become central to many assister organizations***

We believe the post-open enrollment activities that are being proposed as optional have become central to the year-round role that navigators play in their clients lives. In the 2019 Notice, CMS established at §155.210(e)(8) that navigators should target their services to vulnerable and hard-to-reach populations. Yet these

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<sup>3</sup> Kirzinger, Ashley, Bryan Wu, and Mollyann Brodie, "KFF Health Tracking Poll – November 2018: Priorities for New Congress and the Future of the ACA and Medicaid Expansion," Kaiser Family Foundation. (November 28, 2018). Available at: <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2018-priorities-congress-future-aca-medicaid-expansion/>.

are the populations that are more likely to need assistance beyond the enrollment process. As noted in this proposed rule, the ACA requires navigators provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served. In our experience, culturally appropriate service often requires building relationships over time, which is why multi-service community based organizations are best suited to Navigator responsibilities. Consumers will trust an organization more if they not only sign them up for health insurance, but help them use it or help them reconcile the provisions of their tax returns related to it. By requiring Navigators to provide post-enrollment activities, and appropriately compensating them for it, CMS will enhance the ability of navigators to reach their target populations during open enrollment. Further, this supports CMS efforts related to connection to care and encouraging enrollees to appropriately utilize their health care services.

In receiving follow up on their health insurance, consumers expect to be assisted by the same organization who helped them enroll. For example, our partners tell us that assistance with premium tax credit reconciliation is a frequent request they receive and are happy to provide. Some have shared that consumers, who were initially assisted by brokers or agents, come to them for help when filing taxes because the broker or agent intentionally underestimated their income, giving them a lower premium but requiring them to pay back their tax credits when filing their taxes. With tax reconciliation remaining a confusing process for many consumers, it is important navigators be available to guide them through the process.

Navigators also play an important role in helping consumers understand how to use their health insurance and especially their related rights. For the newly insured, this is especially important. Again, our partners tell us that clients they helped enroll will return for help, such as understanding medical bills. A survey by the University of Connecticut found that one out of five respondents did not understand the word “premium,” two thirds did not understand the term “formulary” and two thirds struggled to calculate their cost sharing for a sample hospital bill.<sup>4</sup> And HHS has concluded that racial and ethnic minorities have amongst the lowest rates of health literacy.<sup>5</sup> While we believe that health insurance companies and medical providers play an important role in helping consumers understand these concepts, these institutions lack the trusted relationships and cultural competencies that community based organizations bring.

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<sup>4</sup> Woods, Lauren, "Health Insurance Plans 'Too Complicated to Understand'," UConn Today. (April 5, 2017). Available at: <https://today.uconn.edu/2017/04/health-insurance-plans-complicated-understand/#>.

<sup>5</sup> "America's Health Literacy: Why We Need Accessible Health Information," Office of Disease Prevention and Health Promotion. Available at: <https://health.gov/communication/literacy/issuebrief/>.

If CMS does finalize this proposal against our recommendations, we ask that CMS consider the geographic coverage of entities willing to engage in post-enrollment activities. We suggest that every state and major metropolitan area be served by a navigator entity that provides post-enrollment assistance, though we note with concern that there are currently several states that have no navigator entities at all. We also suggest that CMS ensure the Find Help tool highlights which entities provide post-enrollment assistance.

We are also concerned that CMS proposes to eliminate the training requirements that Exchanges must provide for navigator grantees. While we support the idea of flexibility for Exchanges to cover a wide variety of topics and avoid training that provides little value, we are concerned, considering other recent actions of the agency in cutting consumer assistance, that this change may lead to fewer trainings overall. We urge CMS to ensure Exchanges do not cut resources devoted to supporting navigator education and training. We also echo the comments of the National Health Law Program that navigators must be trained in compliance with Section 1557 of the ACA, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. In particular, for the populations we work with, navigators must be trained in working with limited English proficient populations and providing them with the same level of service as any other consumer.

We do agree with CMS that State Based Exchanges should be free to decide any additional optional or required activities of navigator entities. While there should be a floor of the current standards set in regulations for navigators, states should have the ability to expand on the role of navigators. At this point, many individuals employed as navigators have years of experience that can be drawn upon beyond the task of helping individuals enroll in health insurance, as many of our partners have learned.

Overall, we wish to express our concern with the continued trend of CMS investing resources into technology and policies that facilitate agents and brokers, while minimizing the role of unbiased in person assisters, like navigators. As we describe in our fact sheet, "Health Access Assisters Help Consumers Get the Coverage and health Care They Need," assisters play a significantly different role than brokers and agents, including serving lower income populations with more complex circumstances.<sup>6</sup> In its announcement of the navigator funding opportunity announcement, CMS persisted in comparing the per enrollee costs of navigators and brokers/agents, ignoring the different roles and clientele each work

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<sup>6</sup> "Health Access Assisters Help Consumers Get the Coverage and health Care They Need," Asian & Pacific Islander American Health Forum. (April 2018). Available at: [https://www.apiahf.org/wp-content/uploads/2018/04/March2018\\_HealthAccessAssistersHelpConsumers\\_Factsheet.FINAL\\_.pdf](https://www.apiahf.org/wp-content/uploads/2018/04/March2018_HealthAccessAssistersHelpConsumers_Factsheet.FINAL_.pdf).

with.<sup>7</sup> Yet the Government Accountability Office soon found that the agency, “used problematic data to allocate navigator funding.”<sup>8</sup> We request that CMS desist in undervaluing the role of publicly funded outreach and enrollment.

## **II. § 155.220 Ability of states to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs**

We agree with CMS that it is appropriate to define the term web-broker, as this is a particular business area of growth in the enrollment sector that has potential to cause confusion or worse for consumers without sufficient oversight and standards. We similarly agree in concept about the need to define “direct enrollment technology providers.” Overall, we approve of key provisions in this section that would create greater oversight over the expanding web-broker industry. Consumers, particularly those with little experience in buying and navigating health insurance, can be easily targeted by scams or misleading information. We do wish to point out that, since CMS expanded the use of short term plans, consumers have been bombarded with advertising for plans that likely do not meet their health care needs.<sup>9</sup> We request CMS take a vigorous oversight role in this space.

In redefining provisions that currently apply to web-brokers, creating a separate category for these entities, we urge CMS to ensure it does not create a method for which agents and brokers who do not meet that definition from performing their obligations to ensure consumers have accurate information and that their data is safe. Most agents and brokers have an online presence of some sort, even if they do not utilize direct enrollment websites, and should have to meet minimum standards.

We agree that web brokers should not be able to display QHP selections based on any form of compensation or in any other manner than the one that best facilitates the selection of a plan by a consumer with as much information as they desire. We believe this should explicitly exclude listing plans for which brokers receive compensation at the top of search results or on initial landing pages before a consumer begins the process of plan selection. We also suggest this should exclude any sort of special identifying symbols or words that would lead the consumer to believe these plans are somehow more preferred or exclusive.

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<sup>7</sup> "CMS Announces New Funding Opportunity Announcement for the Federally-Facilitated Exchange Navigator Program," Centers for Medicare and Medicaid Services. (July 10, 2018). Available at: <https://www.cms.gov/newsroom/press-releases/cms-announces-new-funding-opportunity-announcement-federally-facilitated-exchange-navigator-program>.

<sup>8</sup> "Health Insurance Exchanges: HHS Should Enhance Its Management of open enrollment Performance," Government Accountability Office, (July 2018). Available at: <https://www.gao.gov/assets/700/693362.pdf>.

<sup>9</sup> Corlette, Sabrina et al, "The Marketing of Short-Term Health Plans," Georgetown University Health Policy Institute. (January 31, 2019). Available at: <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>.

We also agree that CMS should collect the data of individual brokers and agents that use web-broker websites to enroll consumers in coverage. We suggest that CMS collect this data in a way that allows the agency to analyze trends for individual brokers and agents to identify potential causes for concern, such as agents and brokers who frequently have consumers who are terminated from coverage due to not following up on data matching inconsistencies or who are unusually likely to have consumers owe significant amounts during the tax reconciliation process. We have heard of examples of such problems and believe CMS should proactively identify and address them.

We express our concern that entities that use direct enrollment technology are not required to inform consumers of all of their plan options. The ability of consumers to choose between competing plans, weighing costs, coverage and providers, was a key underpinning of the ACA. For example, Representative Pete Stark noted that the ACA, during the original debate in Congress, would “create a new marketplace, called an Exchange, where people will be able to comparison shop among health insurance plans.”<sup>10</sup> That consumers may be led to enroll through a website into ACA coverage without seeing all of their plans as the default option is counter to the original intent of the law. The proposal to address this concern in this regulation, to require a disclaimer and web link to the Exchange website, is not sufficient.

28.8 percent of Asian Americans are LEP, meaning they speak English less than very well.<sup>11</sup> We are concerned that direct enrollment websites do not serve the needs of LEP populations. For example, four out of the eight partners CMS has approved for use of enhanced direct enrollment technology, for example, do not have in-language taglines on their homepage. While we believe healthcare.gov has a lot of improvements that should be made to make it more accessible to LEP consumers, these websites do not move things in the right direction.

We are also concerned about the proposal to fully exempt web brokers from the trainings required under §155.215(b)(2)8. While web-brokers may be “non-individuals” in terms of who interacts with consumers directly, they are still designed and operated by individuals who must make decisions about how consumers navigate and flow through the website. Therefore, we believe it is important that they be trained in working effectively with individuals with LEP and providing linguistically and culturally appropriate services. As we note above, our review of current enhanced enrollment websites suggests that they are not accessible to LEP populations. We therefore urge CMS to ensure the individuals who are managing these websites are trained in topics that ensure consumers are best served.

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<sup>10</sup> Congressional Record. 111th Congress, 2nd Session Issue: Vol. 156, No. 43, Page H1913. (March 21, 2010).

<sup>11</sup> APIAHF analysis of American Community Survey data, 2017 one year estimates.

We do support the proposal to allow CMS to terminate an agent or broker's agreement with the exchange if the broker or agent fails to meet licensure standards or becomes a threat to exchange operations. An agent or broker acting in bad faith can be deeply damaging to a consumer's access to health insurance, and therefore, to their health. However, we are concerned that current termination procedures do not appear to require brokers or agents to inform consumers of this situation. We believe that once a broker or agent is terminated from the agreement, their customers have a right to know that they must seek out additional assistance should issues arise and also that their personal information is protected. We have heard anecdotes of brokers who retain control over a consumer's username and password to the exchange. In these circumstances, consumers may lose access to their ability to update their account or access it for future enrollment periods. A broker or agent whose agreement has been terminated should be required to ensure consumers have access to all information they need to keep their eligibility up-to-date, though, more broadly, we believe all consumers should have access to this information regardless.

### **III. §155.415 Allowing issuer or direct enrollment entity application assisters to assist with eligibility applications**

We are deeply concerned with the proposal to allow health insurance assisters to utilize direct enrollment entities to enroll consumers in health insurance, rather than being limited to using the Exchange website. This concern is exacerbated by the fact, as stated earlier in our comments, that these websites may also sell coverage that does not provide the full scope of ACA benefits and protections.

We consulted with our partners that conduct health insurance outreach and enrollment as to their desire to utilize websites other than the official Exchange website. They unanimously express no desire to use these websites and in fact, expressed concern about any assister doing so. Health insurance assisters, such as navigators and Certified Application Councilors, gain consumer trust by marketing themselves honestly as unbiased sources of information and assistance. Consumers know by turning to these groups, unlike agents and brokers, there is not a profit motive that might lead the assister to give advice that is anything other than in their interest.

### **IV. § 155.420 Special enrollment periods**

We applaud CMS for the addition of a special enrollment period (SEP) that allows consumers to enroll in on-exchange coverage, moving from off-exchange plans, should they become eligible for premium tax credits. This proposal would mean more consumers are able to access affordable health insurance when their circumstances change, instead of having to wait for the next open enrollment period. We encourage CMS to consider additional opportunities for expanding SEPs for when consumer's circumstances change and to consider options that

reduce the burden placed on consumers to provide extensive verification information that may discourage them from completing an SEP application.

**V. § 156.280 Rules relating to coverage of abortion services and segregation of premiums for such services**

We oppose the burdensome proposal in this proposed rule that would require health insurance providers who offer plans that cover abortion services to offer an equivalent plan that does not cover those services. This proposal would lead to increased consumer confusion and unnecessary costs for the insurance providers putting resources into creating these plans, who may ultimately decide to avoid the duplication required by this new provision and offer no abortion coverage.

This proposal undermines the carefully orchestrated agreement around coverage of abortion services that Congress reached in passing the ACA, which permitted plans to offer abortion coverage in the Exchange if they so choose. Section 1303 of the ACA sets out “special rules” that an insurance plan participating in the ACA marketplace must follow in order to cover abortion beyond the limited exceptions allowed under the discriminatory and harmful federal Hyde Amendment.<sup>12</sup> While these rules painfully and unnecessarily impede access to abortion care, there is no question that Congress carefully crafted this language, considering the extensive debate at the time.

Contrary to CMS’s stated goals throughout this proposed regulation, this requirement would likely lead to higher premiums for consumers, who would bear the brunt of the increased cost for insurance companies developing, reviewing and maintaining these additional plans, which, for some companies, may essentially double the number of plans they offer. It also will lead to increased burden for all entities engaging in consumer assistance, who will have to explain another layer of complexity in the enrollment process to their clients or customers.

We believe that health insurance must cover the full range of health services that a person might need throughout their lifetime, including abortion services. AAPI women account for roughly 6 percent of abortion patients, with disproportionate numbers of AAPI foreign-born women experiencing higher rates of abortion.<sup>13</sup> It is inappropriate for the federal government to step in and require plans to offer additional coverage options if they have chosen to cover non-Hyde abortion services.

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<sup>12</sup> Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1303 (2010), amended by Health Care and Education Affordability Act, Pub. L. No 111-152 (2010). See also “Hyde Amendment” Dep’t of Defense and Labor, Health and Hum.

<sup>13</sup> Jerman J, “Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008.” Guttmacher Institute. (May 2016). Available at <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>.



For consumers who, as a result of this policy, face a market with no insurance options that cover abortion this plan will mean either paying out-of-pocket for the abortion or denial of abortion care, which bears its own economic and health risks. The average costs to patients for first-trimester abortion care was \$461 in one study, and anywhere from \$860 to \$1874 for second-trimester abortion care.<sup>14</sup> Another study found that a woman who seeks but is denied abortion care is more likely to fall into poverty than a woman who is able to get the care she needs.<sup>15</sup> As such, CMS should not adopt this proposal.

## **VI. § 156.130 Premium adjustment percentage**

We oppose the proposal to include insurance purchased on the individual market in the annual calculation of premium growth. Doing so would impact consumers who receive premium tax credits by increasing the percent of their premiums a consumer is responsible for and raising the amount of cost sharing families are faced with. CMS should be taking action to reduce costs for quality health care for consumers, yet this proposal would do the opposite.

CMS is up front about the bad faith in which this proposal is being considered. As stated in the proposed rule, calculating the percentage using both the individual and employer markets, when compared to just using employer markets, will lead to higher out-of-pocket maximums and premium cost sharing requirements for enrollees. It also will raise the percent of income used in determining whether an employer plan is affordable. All of this will result in at least 100,000 people losing marketplace coverage and higher premiums for 7.3 million marketplace customers.<sup>16</sup>

Despite these harmful impacts, it appears CMS is motivated to finalize this change because, “federal outlays for the premium tax credit increased significantly in the 2018 benefit year, as many issuers increased silver plan premiums to offset the cost of providing cost sharing reductions to eligible enrollees” and therefore it “would help to slow the increase in premium tax credit expenditures that results from this practice, thereby reducing taxpayer burden associated with premium tax credit expenditures.” We remind CMS that these higher federal outlays were caused by the Administration’s decision to stop paying cost sharing reduction payments and is entirely unrelated to the premium

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<sup>14</sup> "Research brief: The impact of out-of-pocket costs on abortion care access", All Above All and Ibis Reproductive Health. (September 2016). Available at: <https://allaboveall.org/wp/wp-content/uploads/2016/09/OutOfPocket-Impact.pdf>.

<sup>15</sup> Greene Foster, Diana, Sarah C. M. Roberts, and Jane Mauldon, “Socioeconomic consequences of abortion compared to unwanted birth,” Abstract from the American Public Health Association’s annual meeting. (2012). Available at <https://apha.confex.com/apha/140am/webprogram/Paper263858.html>.

<sup>16</sup> Aron-Dine, Aviva and Matt Broaddus, "Change to Insurance Payment Formulas Would Raise Costs for Millions With Marketplace or Employer Plans," Center on Budget and Policy Priorities. (January 18, 2019). Available at: <https://www.cbpp.org/research/health/change-to-insurance-payment-formulas-would-raise-costs-for-millions-with-marketplace>.

adjustment percentage. It is therefore inappropriate for the agency to try to reduce federal outlays by using reasoning that the section of the statute authorizing the Secretary to set the premium adjustment percentage makes no mention of.

Section 1302(c)(4) of the Affordable Care Act states that, “For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).” Again, we note that the Secretary is only authorized to estimate average per capita premiums, with no other factors, such as federal outlays, being mentioned as things the Secretary can consider.

As discussed in the proposed rule, CMS considered, and rejected, adopting the proposed calculation in the 2015 Notice. In that final rule, CMS noted that, “after the initial years of implementation of market reforms, once the premium trend is more stable, we may propose to change our methodology.” It is clear that the premium trend is not more stable at this point in time, particularly because of uncertainty in the market around federal government actions. For example, the Wall Street Journal noted in July of last year that CMS’s decision to halt risk adjustment payments, “Adds to insurers’ uncertainty.”<sup>17</sup> In addition, this is the first year that the new rules encouraging the spread of short term limited duration plans and association health plans have taken effect, which may further disrupt the markets.<sup>18</sup>

As we noted earlier, the ACA has led to record low uninsured rates for AAs and NHPIs. In fact, as noted by a group of experts including former Assistant Secretary for Health Howard Koh, it has helped to virtually eliminate disparities for some groups.<sup>19</sup> This proposal would readily undo those gains. As such, we urge CMS to reject this new formula.

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<sup>17</sup> Wilde Mathews, Anna and Stephanie Armour, “Trump’s Latest Affordable Care Act Move Adds to Insurers’ Uncertainty,” Wall Street Journal. (July 8, 2018). Available at: <https://www.wsj.com/articles/trumps-latest-affordable-care-act-move-adds-to-insurers-uncertainty-1531080964>.

<sup>18</sup> Meyer, Harris, "Renewable short-term plans pose new challenge for ACA market," Modern Healthcare. (November 2, 2018). Available at: <https://www.modernhealthcare.com/article/20181102/NEWS/181109972>.

<sup>19</sup> Park, John et al, "More than 1 Million Asian Americans, Native Hawaiians, and Pacific Islanders Have Gained Coverage Under the Affordable Care Act," Academy Health. (Oct 16, 2018). Available at: <https://www.academyhealth.org/blog/2018-10/more-1-million-asian-americans-native-hawaiians-and-pacific-islanders-have-gained-coverage-under-affordable-care-act>.

## **VII. The Automatic re-enrollment processes**

We support the continuation of the Exchange using automatic re-enrollment of a consumer's plan, or equivalent if the plan is not being offered again, should a consumer not take action to enroll in a new plan or discontinue their insurance. While we encourage consumers to shop around, and believe that CMS should expend more resource leading up to and during open enrollment to do the same, many have come to rely and expect to be auto-renewed in their plan. This is particularly important given that open enrollment occurs during the holiday season and busy end of the year period, when many may find it difficult to go through the full enrollment process. As noted earlier, polls show consumers are generally unaware of the open enrollment deadline. We also note that HHS's decision to shorten open enrollment reduces opportunities for consumers to fully review their options and potentially select a different plan.

The proposed rule also asks for feedback on "additional policies or program measures that would result in eligibility errors." APIAHF supports accurate eligibility determinations that reduce the likelihood of consumers later losing their insurance or having to repay premium tax credits. However, we also have expressed concerns since the first open enrollment period that verification systems can be burdensome on consumers, particularly for immigrants who may have complex family situations or shorter credit histories. In particular, in recent years, CMS has added additional burdens on consumers, such as adding data matching on income for consumers near 100 percent of poverty. See our brief, "Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities," for some specific examples of how such systems can burden vulnerable populations.<sup>20</sup> CMS should work to improve its automatic determination systems so that consumers face reduced burdens in documenting their eligibility, while providing robust opportunity for appeals and corrections when these systems are in error.

## **VIII. Silver loading**

CMS requests comment on ways the agency might address silver loading, the practice of states permitting issuers shifting the increased premiums resulting from the Administration's refusal to pay cost sharing reduction payments onto silver plans, instead of spreading the increased costs out on all plans. This practice has allowed the exchange market to maintain some level of stability in the face of actions by this Administration. Therefore, we support CMS's decision not to alter its policies on silver loading and urge it, in future years, to allow the market to

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<sup>20</sup> "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. (September 2014). Available at: [https://www.apiahf.org/wp-content/uploads/2014/10/2014.10.14\\_Improving-the-Road-to-ACA-Coverage\\_National-Report-1.pdf](https://www.apiahf.org/wp-content/uploads/2014/10/2014.10.14_Improving-the-Road-to-ACA-Coverage_National-Report-1.pdf).

continue that stability and do not alter the ability of states to allow issues to utilize silver loading in setting their premiums.

**IX. §156.50 User fee rates for the 2020 benefit year**

We urge CMS to maintain the use fee rate for the federal exchange at the current 3.5% in order to ensure the Exchange can meet customer's needs. As we have stated, the cuts CMS has made to outreach and enrollment programs have been harmful to consumers, reducing the number of people who are aware of their opportunity to enroll and making that process more difficult. We are also concerned that CMS is not devoting sufficient resources to capital improvements, particularly in technology that would allow for translated notices to be sent out. Currently, despite the fact that a consumer's preferred written language is collected on the application, the Exchange does not send critical documents, such as the eligibility determination notices, data matching issues and terminations. Every year, our partners inform us of consumers who are LEP who receive written notices in English and either fail to understand their importance or mistakenly discard them because they cannot understand them. Therefore, it would be appropriate for CMS to maintain the current user fee rate and invest its resources in improving the consumer experience, in addition to restoring funding for outreach and enrollment.

**X. Prescription drug access**

We raise serious concerns about the proposed changes that would permit mid-year formulary changes. Currently, plans cannot modify coverage, including generally changes in drug formularies, except when the plan is renewed each year. This critical protection ensures that consumers are able to actively shop for plans that meet their needs, including providing coverage for prescription drugs they are using. Indeed, coverage for prescription drugs and location on a plan formulary is often a major consideration for consumers with complex health needs. Yet, CMS now proposes to allow plans to remove a brand-name drug if a generic equivalent becomes available, which would undermine essential health benefit protections. This could particularly harm consumers who require complex and specific therapies, such as treating HIV/AIDS where formulations of drugs are critical and cannot easily be substituted. As such, we urge CMS to withdraw the proposal to allow plans to remove brand-name drugs, but instead allow plans to add generics as they become available.

Thank you for the opportunity to comment on this proposed rule. Please do not hesitate to contact Ben D'Avanzo, Senior Policy Analyst ([bdavanzo@apiahf.org](mailto: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