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

Alex Azar, Secretary
Randy Pate, CMS Deputy Administrator & CCIIO Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9916–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

February 28, 2020

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans CMS–9916–P; RIN 0938–AT98

Dear Secretary Azar and Deputy Administrator Pate:

The Asian & Pacific Islander American Health Forum (APIAHF) submits this comment letter in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment parameters for 2021 proposed rule ("proposed rule"). We raise concerns about several issues impacting consumers, and particularly those who are racial and ethnic minorities, limited English proficient, have health literacy and literacy challenges and may not be familiar with the U.S. health care system. **In particular, we strongly oppose the auto reenrollment proposed changes as they will further compound barriers to attaining eligible coverage that consumers already experience.**

APIAHF is the nation's leading health policy organization working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) across the U.S. and territories. APIAHF works to improve access to and the quality of care for communities who are predominately immigrant, many of whom are limited English proficient, and may be new to the U.S. health care system or unfamiliar with private or public coverage. We have longstanding relationships with over 100 community-based organizations across 34 states and the Pacific, to whom we provide capacity building, advocacy and technical assistance. 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.

As such, we have a strong understanding of the needs and barriers experienced by AA and NHPI communities across the country and the impact that changes outlined in the proposed rule would have on those individuals and communities.

I. Auto Reenrollment

Under current rules, if a consumer does not update their income during marketplace open enrollment, the health plan renews for the next year with the same tax credits. HHS proposes to stop this automatic renewal if the enrollee's tax credit covers the full cost of the premium and the enrollee pays $0. If consumers do not update their income and other financial information, they would have to pay a premium to reenroll. HHS proposes to withhold some or all of their tax credits until the consumer updates their financial information, even if there are no changes to report. According to the proposed rule, 1.8 million people were automatically reenrolled in coverage for 2019, including 270,000 people with $0 premiums.

HHS says it would conduct outreach about this new process and reach out to consumers affected by such a change. Yet many people do not know they should update their information during open enrollment and have been auto-reenrolling with $0 premiums for a number of years. The result is they may not renew their plan if they get a bill from the insurance company for the full amount (even if they could get APTCs restored if they update their information or obtain a refund from reconciling when they file their federal income taxes). And outreach has not always proven effective in reaching certain consumers, due not only to confusion about how health insurance works but also language barriers and low health literacy.

We are very concerned that this proposal, whether the consumer would have to pay all or part of the premium to renew, would lead many individuals to lose their coverage. **As such, we strongly recommend HHS retain the current policies regarding automatic reenrollment.**

APIAHF's experience, and that of the community-based organizations that we partner with, during past enrollment periods clearly shows the negative outcomes that this change would have, particularly when coupled with significantly reduced outreach and enrollment assistance from CMS.

For example, community-based organizations serving diverse consumers, including AAs and NHPIs and those who are limited English proficient, have reported for years the inability of many of those persons to understand legal notices received from the Marketplace, including those related to annual enrollment, financial assistance and missing documentation. This has resulted in consumers having to appeal coverage determinations or having their coverage terminated as a result of not submitting required documentation. The proposed policy, if adopted, would compound those issues and result in consumers losing coverage with financial assistance they otherwise would have been eligible for.

In the 2019 Notice of Benefit and Payment Parameters, and previous funding opportunities for navigators, CMS has taken drastic steps to limit 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. APIAHF expresses serious concern that CMS will be able to implement the proposed autoenrollment change without harming consumers because it has already substantially reduced outreach, education and in person assistance through navigators. CMS has reduced funding for the navigator program by 80% and outreach and enrollment efforts by 90%.

While we encourage consumers to shop around and believe that CMS should expend more resources leading up to and during open enrollment to do the same, many have come to rely upon and expect to be automatically 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. 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 would compound the negative impacts outlined in this letter that would result from the proposed new auto reenrollment policy.

II. Essential Health Benefits

We oppose the proposal to require states to annually report benefit mandates enacted through state law. The ACA requires states to identify and defray the costs for mandates enacted after December 31, 2011. However, given that the Center for Consumer Information and Insurance Oversight's (CCIIO) already publishes state mandates and year of enactment on its website, HHS's proposed annual reporting requirement is unduly complicated and burdensome to states.[1] The proposal will effectively transfer authority to determine what constitutes a state mandate from state authorities to HHS. Moreover, the rule, if implemented, will discourage states from improving coverage in the individual and small group market using existing regulatory authority under the EHB benchmarking process.

HHS provides no evidence showing that states are violating this federal requirement. In addition, the proposal will render state authority over mandate determinations meaningless, contrary to the intent of both the ACA and corresponding HHS regulations.

The proposal would also impose such a burdensome requirement that it will deter states from improving their EHB benchmark plans. Several states are using current authority to update their EHB benchmark plans and expand services in critical areas. Under HHS' proposal, states would need to submit an annual report that: identifies all state-required benefits regardless of whether those

[1] See https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#ehb.

benefits are considered part of EHB; provides information explaining why the state believes the mandate is or is not part of EHB; and provides information about any mandate that has been amended or repealed. States will likely be reluctant to improve or expand benefits under the EHB benchmarking process, fearing that such improvements may run afoul of the complex mandate reporting requirements.

These requirements represent a significant departure from the current standard, which requires states to inform HHS of state mandates and their corresponding date of enactment, without additional explanation for why the state believes the mandate triggers or does not trigger defrayal. Adopting these new requirements will effectively transform a workable and simple task into an arduous and complicated endeavor put in place as a solution to an inexistent problem. We urge HHS to withdraw this proposal.

III. User Fees

We do not support a reduction in marketplace user fees at this time. User fees are essential to operate the marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. Over the years, we have identified a number of issues that should be addressed throughout healthcare.gov, both to enhance the consumer experience and also address other behind-the-scenes issues. For example, CMS has previously noted it is currently unable to tailor in-language resources with a consumers' selected preferred language and that such a change would require changes to Healthcare.gov at a technical level. We believe HHS should maintain the current user fees until it completes much needed fixes and enhancements.

Further, HHS should increase funding for navigator program, outreach and assistance and restore them at least to 2016 levels, given in recent years the navigator program has been cut by 80% and outreach and enrollment assistance by 90%. If user fees were to be reduced further, we are deeply concerned that such a reduction would result in additional cuts to these critical programs.

IV. Special Enrollment Periods

We appreciate the consumer-friendly changes in special enrollment periods that would allow consumers to move to a higher or lower metal level plan if they became newly eligible for cost-sharing reductions. We also appreciate the acceleration of effective dates so that consumers will not have to wait as long for coverage to become effective.

V. Appeals

We are concerned about limiting the choice of consumers to choose either full retroactive coverage or only prospective coverage if successful with their appeal.

Consumers should have the option to request either full or partial retroactive coverage.

HHS notes that issuers have indicated it is difficult to determine how to apply a binder payment given the potential of different circumstances involved (specifically mentioning appeal, non-verified Special Enrollment Period (SEP), or SEP with a delay in verification processing). However, if the sole issue is the difficulty of determining an appropriate binder payment, we recommend that HHS develop new processes to more clearly identify the type of binder payment rather than eliminate the option of partial retroactive coverage for consumers. Some consumers may have valid reasons for requesting partial retroactive coverage. A consumer may have been in an accident or been diagnosed with a new condition or illness during pendency of an appeal that required timely treatment. When successful in the appeal, the consumer may want to obtain retroactive coverage only back to the date of incident or diagnosis rather than the date of application. Depending on how long the appeal took to resolve, it may be a financial hardship for a consumer to have to pay for a long period of retroactive coverage while at the same time could be financially burdened if partial retroactive coverage is not available.

Additionally, in response to HHS' request for comments, we provide the following feedback:

- Appellants who request and are granted eligibility pending appeal should be permitted to enroll in any plan and not be limited in any way to a particular issuer or metal level;
- HHS should not adopt a timeliness standard for requesting eligibility pending an appeal;
- Consumers who experience life events during pendency of an appeal should have their appeals considered resolved in their favor, especially with regards to requests for continuation of benefits pending an appeal and requests for retroactive coverage;
- HHS should apply the three-month grace period to any appeal for which the grace period would normally apply and prohibit issuers from terminating coverage pending an appeal.

VI. Co-Pay Accumulator Programs

Despite having insurance coverage, many consumers struggle to afford prescription drug therapies due to high out-of-pocket costs. For this reason, many consumers rely on pharmaceutical manufacturers' coupons to help defray cost sharing. However, in the proposed rule, health insurance companies (issuers) would be allowed to not count coupons towards a consumer's deductible and out-of-pocket maximum.[2] As a consequence, when coupons run out, the consumer may be required to pay the full amount for a drug until meeting the

[2] 85 Fed. Reg. 7158, to be codified as 45 C.F.R. § 156.130(h).

deductible; and continue to pay cost-sharing until reaching the out-of-pocket maximum. As a result, many patients may no longer be able to access potentially life-saving medication because they cannot afford it, leading to disruptions in treatment and worse health outcomes.

When HHS considered this same issue two years ago, it decided to limit insurance companies to count coupon amounts for brand drugs unless a generic equivalent is available. HHS reasoned that manufacturers were offering coupons to steer consumers toward higher cost, brand name drugs. However, under the current proposal, insurance companies would be allowed to not count coupons even when no generic equivalents exist.

HHS does not explain any reason for this change in the proposed rule. Moreover, issuers already have tools available to help steer consumers to lower cost drugs. Many issuers require prior authorization for brand name drugs, or step therapy whereby consumers must try and a cheaper generic version first, before being approved for a brand name drug. Yet for some prescription drugs, like contraceptives, and for some medical conditions like MS where treatment is highly individualized, even step therapy is not appropriate.

As such we strongly urge the administration to withdraw this proposal.

Thank you for the opportunity to comment on the proposed rule. For questions, please contact Ben D'Avanzo, APIAHF Senior Policy Analyst at bdavanzo@apiahf.org.

Sincerely,

Juliet K. Choi
APIAHF Executive Vice President