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

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P, P.O. Box 8016
Baltimore, MD 21244-8016

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services

**Re: RIN 0938-AU65; CMS-9911-P
Patient Protection and Affordable Care Act; HHS Notice of Benefit and
Payment Parameters for 2023**

Dear Administrator Brooks-LaSure and Director Montz:

The Asian & Pacific Islander American Health Forum (APIAHF) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Patient Protection and Affordable Care Act (ACA); HHS Notice of Benefit and Payment Parameters for 2023 (hereinafter NBPP 2023 Rule).

APIAHF is the nation's leading health policy organization working to advance the health and well-being of over 25 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 predominantly immigrant, many of whom are limited English proficient, and may be new to the U.S. healthcare system or unfamiliar with private or public coverage. We have longstanding relationships with over 150 community-based organizations over 40 states and the Pacific, to whom we provide capacity building, advocacy and technical assistance.

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

I. Guaranteed availability of coverage: Past due premiums (§ 147.104)

We strongly support revising HHS' interpretation of the ACA's guaranteed issue provision to allow individuals to enroll in coverage even if they have past-due premiums. In the proposed rule, HHS revises its previous interpretation of the ACA's guaranteed issue provision which allowed insurers to refuse to cover persons who owe past due premiums until they satisfy arrearages. We strongly support revising this unlawful interpretation of the guaranteed availability provision. The statute is clear – an issuer “must accept every employer and individual in the State that applies for such coverage.”¹ As HHS now acknowledges, denying coverage because of past-due premiums is contrary to the ACA, and disproportionately hurts persons who are low

¹ 42 U.S.C. § 300gg-1(a).

income and others experiencing economic hardship. Especially given the ongoing and devastating impact of the COVID-19 pandemic, no one should lose or be denied health care.

Prior to the ACA, the uninsured rate was 15.1% for AAs, and 14.5% for NHPs. The ACA's public and private coverage expansions cut the uninsured rate in half for AAs to 6.5% and nearly half for NHPs to 7.7% by 2016.² Despite these historic gains, uninsured rates vary widely across AA and NHP groups, with NHPs experiencing uninsured rates of 12.3% in 2019. Health disparities within AA and NHP communities remain due to varying degrees of poverty, immigration status, lack of cultural competency in the health care system, and language access barriers. Additional barriers to health coverage, including denying coverage based on past-due payments, will likely worsen the coverage gap among the most vulnerable in our community and reverse the progress made by the ACA.

II. Nondiscrimination on the basis of sexual orientation and gender identity (Part 147) (§§ 147.104(e), 155.120(c), 155.220(j), 156.125(b), 156.200(e), and 156.1230(b)).

We support HHS's proposal to prohibit Exchanges, insurers, and agents and brokers from discriminating based on sexual orientation and gender identity. It is well-established that members of the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community face discrimination when seeking health care, resulting in poorer health outcomes than their straight and cisgender peers. Insurers specifically have contributed to this discrimination by employing [transgender-specific exclusions](#) to deny coverage for medically necessary treatment, including but not limited to gender-affirming treatment. The current rule has and continues to exacerbate these disparities.

The proposed regulatory amendment is within HHS's authority and consistent with the ACA's intent to improve access to health coverage and services and to prohibit discrimination in the provision of health care. Provisions of the ACA indicated Congress's intent for the law to prohibit unreasonable barriers to obtaining appropriate medical care and remove limits on the availability of the full scope of health care a person needs. (Pub. L. No. 111-148, sec. 18144 [Section 1554 of the ACA].) The current rule is contrary to these aims, instead permitting and creating barriers to comprehensive care.

[APIAHF applauded HHS in May 2021](#), when it announced that enforcement of Section 1557 of the ACA and Title IX's prohibitions on discrimination based on sex will include prohibitions against discrimination based on sexual orientation and gender identity. Section 1557 of the ACA clearly indicates that the law intended to prohibit discrimination in health care, and this proposed rule is a critical step in restoring Section 1557 and ending discrimination in covered health care. For all these reasons, HHS should act to prohibit discrimination on the basis of sexual orientation and gender identity in this regulation.

III. Federally-Facilitated Exchange (FFE) and State-Based Exchange on the Federal Platform (SBE-FP) User Fee Rates for the 2023 Benefit Year (§ 156.50)

We strongly support a robust user fee to allow HHS to undertake a series of needed activities, including funding the navigator program. HHS anticipates that spending on consumer outreach and education, eligibility determinations, and enrollment processes will need to increase by \$140 million above the 2022 benefit year level. This is in part due to projected enrollment declines when the enhanced premiums of the American Rescue Plan Act expire. HHS should consider the increased marketing and outreach efforts needed to effectively enroll consumers in the FFEs and SBE-FPs in 2023, and incorporate adequate funding in the user fee rates, even if this means a slight increase in the user fee rates.

² APIAHF, Snapshot: Asian American, Native Hawaiian, and Pacific Islander Health (Aug. 2019). Available at: https://www.apiahf.org/wp-content/uploads/2017/09/August2019_SnapshotAANHPIHealth_Factsheet-3.pdf.

The marketplace user fee - a fixed percentage of premium revenue paid by insurers - supports critical functions, including the operation and improvement of the navigator program. We greatly appreciate HHS' substantial increase in navigator funding over the past year. We believe a strong navigator program is essential to ensuring individuals have the fair, accurate and impartial information they need to select and enroll in a plan. Yet, we would recommend even greater funding which could be supported by user fees.

Navigators fulfill a critical role in providing outreach and supporting vulnerable communities in learning about and enrolling in their coverage options. APIAHF partners with community-based organizations with navigator programs serving diverse consumers, including AAs and NHPIs, those who are limited English proficient, and those who are new or unfamiliar with the U.S. healthcare system. Many of our partner community-based organizations have shared the experiences of community members who are unable to understand their eligibility for coverage or legal notices received from the Marketplace, including those related to annual enrollment, financial assistance, and missing documentation.

In one instance, our partners at HOPE Clinic assisted a limited English proficient nail salon worker who suffered hardships during the COVID-19 pandemic. She was not aware of the ACA special enrollment period but was glad to receive information and speak to someone in Vietnamese during one of HOPE Clinic's outreach events. After learning about the special enrollment period, she was eager to receive assistance with her application.

There are countless stories, like the one shared by HOPE Clinic, where navigators are often the link to making health coverage accessible for underserved and isolated communities. Navigators are unique in that many are based in community-based organizations with established and trusted relationships with people and communities who are likely to be eligible to enroll in QHPs. When extensive budget cuts were made to navigator programs starting in 2017, we saw increases in uninsured rates in AA and NHPI communities. With the increased funding to support needed activities, like navigator programs, we can invest in closing the gap on health access through programs that are proven to be effective.

IV. Risk Adjustment Issuer Data Requirements (§ 153.610, 153.700 and 153.710)

APIAHF supports the data collection and extraction requirements for risk adjustment, including the addition of information about race and ethnicity to EDGE data. 45 CFR 153.610(a) requires that health insurance issuers of risk adjustment covered plans submit or make accessible all required risk adjustment data in accordance with the data collection approach established by HHS. HHS proposes to collect and extract five new data elements (ZIP code, race, ethnicity, subsidy indicator, and ICHRA indicator) to enrollee-level External Data Gathering Environment (EDGE) data. Specifically, requiring issuers of risk adjustment to report race and ethnicity would be in accordance with the 2011 HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. The usage of additional data elements in determining risk calibrations and in assessing any risk patterns or impacts of risk adjustment policies would allow issuers and HHS to better analyze and assess health equity impacts more than current data allow.

APIAHF has continuously raised the issue of the lack of timely and accurate data on AA and NHPI populations. Our communities cannot be visible without data that accurately reflects the experiences we face. Communities of color are disproportionately affected by chronic illness and have higher uninsured rates, leading to poor health outcomes. During the pandemic, we have witnessed how COVID-19 disproportionately impacts communities of color and the challenges our public health system continues to face in effectively understanding this pandemic because of the lack of detailed disaggregated demographic data. The collection and extraction of demographic characteristics, such as race and ethnicity, should mirror the standards established by Section 4302 of the Affordable Care Act. (These new HHS data standards for race and ethnicity include additional granularity, for Hispanic (four additional categories) and Asian subpopulations (7 additional categories) beyond the OMB minimum standard categories.) This type of granular data will allow health insurance issuers as well as HHS (and the public) to more meaningfully understand the relationship between risk patterns and demographic

characteristics at a more granular level and to adjust policies in ways that can impactfully address health disparities.

V. Quality Standards: Quality Improvement Strategy (§ 156.1130)

We support this proposed rule but ask that CMS require more public transparency and accountability about the process, including soliciting input on quality improvement strategy (QIS) activities in the preferred language of enrollees. The proposed rule would require all Qualified Health Plans (QHPs) with at least two consecutive years in a market to include in their quality improvement strategies (QIS) at least one payment structure that provides increased reimbursement or other financial incentives for activities aimed at reducing health and health care disparities. Additionally, HHS proposes to update the QIS standards and adopt a new guideline under which QHP issuers would be required to address health and health care disparities, in addition to at least one other topic area defined in statute: improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, and promoting wellness and health.

Although the proposed QIS policy ties effective performance on reducing health and health care inequities to financial reward, it lacks two important elements. First, QHPs should have to seek input from underserved enrollees, including limited English proficient (LEP) enrollees, or stakeholders who represent underserved communities to guide their QIS activity selection – to shape which activities related to health or health care inequities they prioritize. Second, more public accountability is necessary to reassure the public that issuers (and CMS) take these initiatives seriously.

APIAHF urges CMS to require QHPs to solicit input and provide QIS materials in the preferred languages of enrollees. Approximately 25 million individuals in the U.S. are limited English proficient (LEP), meaning that they speak little to no English. 1 in 3 AA and NHPs are LEP, and as a result face barriers to accessing enrollment and benefits, as well as providing feedback on their experiences with healthcare systems and health plans. CMS’s guidance requires exchanges, qualified health plan issuers, and web-brokers provide meaningful access to LEP speakers – this includes meaningful access to QIS and the benefits attached.

Conclusion

Thank you for the opportunity to submit comments on the proposed rule. Please do not hesitate to contact my staff at policy@apiahf.org if you have any questions or need any further information.

Sincerely,



Juliet K. Choi
President & CEO