



July 28, 2021

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-9914-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-9906-P – Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule (RIN 0938–AU60)

Dear Secretary Becerra and Administrator Brooks-LaSure,

The Cancer Support Community (CSC), an international nonprofit organization that provides support, education, and hope to cancer patients, survivors, and their loved ones, appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) proposed rule “Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond.” As the largest provider of social and emotional support services for people impacted by cancer, CSC has a unique understanding of the cancer patient experience. In addition to our direct services, our Research and Training Institute and Cancer Policy Institute are industry leaders in advancing the evidence base and promoting patient-centered public policies.

The Affordable Care Act (ACA) is a critical safety net for the nearly 17 million cancer patients and survivors across the U.S., including protections for people with pre-existing conditions and eliminating patient cost-sharing for essential health benefits, such as critical cancer screening tests. A record 31 million people are currently receiving quality, comprehensive, and affordable health care under the ACA, through health insurance marketplaces and Medicaid expansion (HHS, 2021).

We appreciate the actions that the Administration has taken to strengthen the ACA and applaud the several provisions in the proposed rule that will expand enrollment opportunities, reduce the number of uninsured people, and strengthen and restore patient protections and programs afforded by the ACA.

Navigator Program Standards

We were pleased to see that the proposed rule would reinstate previous requirements for Navigators to assist consumers in certain post-enrollment marketplace activities. The proposed rule would require Navigators to help consumers file appeals on Exchange eligibility determinations, understand basic concepts and rights associated with health coverage, apply for an exemption to maintaining minimum essential coverage from the exchange; help consumers reconcile advance premium tax credits (APTC), and find assistance with tax filing.

Evidence shows that many people find the process of learning about health coverage options and applying for financial help overwhelming and complex (Pollitz et al., 2020). Many people also lack basic health literacy. According to the National Assessment of Adult Literacy, assessed by the Department of Health

and Human Services (HHS), only 12% of American adults have proficient health literacy (National Assessment of Adult Literacy, 2006). Approximately 14% of adults, or 30 million people, reported below basic health literacy, and were more likely to report their health as poor (National Assessment of Adult Literacy, 2006).

People enrolling in the marketplace, including those impacted by cancer, need reliable assistance from Navigators to choose appropriate and comprehensive health coverage for themselves and their families. We were **strongly opposed** to the cuts to the funding for Navigators that occurred in recent years due to concerns that disinvestment in the program would only serve to increase health literacy disparities and leave consumers to fend for themselves in a fight for their access to quality health care. Reinstating the Navigator requirements will help to ensure that more patients receive trusted assistance in navigating their care options and enrolling in coverage.

Expanded Open Enrollment

The ACA became even more important during the COVID-19 public health emergency and the subsequent economic downturn for millions of individuals and families nationwide. We applaud the steps that the Administration has taken in creating a Special Enrollment Period (SEP), which has, to date, allowed more than 2 million people enroll in health insurance at HealthCare.gov (CMS, 2021).

Giving people more time to enroll in health coverage means that more people can receive assistance from Navigators and select the plan that best meets their needs. As such, we strongly support extending the annual open enrollment period. We appreciate that the proposed rule alters the open enrollment period for the 2022 coverage year to run through January 15, and further urge CMS to restore the open enrollment period to the full 90 days (to January 31). Extending open enrollment will greatly benefit consumers as well as help reduce the number of people uninsured.

Restoration of Section 1332 Waiver Guardrails

Section 1332 of the ACA allows states to apply for a state innovation waiver to pursue innovative strategies to provide their residents with high quality, affordable health care coverage while retaining the basic protections of the ACA. The law requires that innovation plans meet four guardrails:

1. Provide coverage that is at least as comprehensive in covered benefits;
2. Provide coverage that is at least as affordable (taking into account premiums and excessive cost sharing);
3. Provide coverage to at least a comparable number of state residents; and
4. Not increase the federal deficit. (Tolbert & Pollitz, 2018).

In 2015, the Obama Administration published guidance interpreting these guardrails in a manner that solidified these substantive protections in the ACA, ensuring coverage is comprehensive, affordable, and accessible (CMS, 2015). In 2018, however, the Trump Administration published new guidance that applied a pliable interpretation of the guardrails. In our **comments** on the Notice of Benefit and Payment Parameters for 2022 Proposed Rule (2022 NBPP), we strongly opposed codifying the 2018 Guidance that we contended undermines the goals of the ACA and weakens the protections the ACA intended to confer on patients.

CSC wholly supports innovative health coverage, but only if that coverage is comprehensive, affordable, and accessible. Coverage that sacrifices one or more of these guardrails to achieve another does not meet the 1332 waiver requirements established by the ACA. Truly innovative health coverage simultaneously

empowers both the patient as well as the state. The aim to lower barriers to innovation must not impose barriers that override the guardrails Congress saw fit to adopt to achieve the aim of the ACA.

For the reasons listed above, we applaud the decision to revoke the interpretations codified by the 2022 NBPP and restore the guardrails that must be met by any waiver application under Section 1332 of the ACA.

Exchange Direct Enrollment Option

We strongly support repealing the Exchange Direct Enrollment Option for state exchanges, state-based exchanges on the federal platform (SBE-FP), and federally facilitated exchange (FFE). This option would have permitted state exchanges to circumvent the ACA Marketplaces and require enrollees to use private insurers and web-brokers to compare plans, apply for financial assistance, and enroll in coverage. In our [2022 NBPP comments](#) we urged HHS not to finalize this policy because of the negative consequences it would have on people's ability to access affordable and comprehensive health coverage.

The 2022 NBPP's efforts to not only expand the opportunity to eliminate HealthCare.gov to more states, but to do so without the need for states to set forth their plan through a formal 1332 waiver request encourages, rather than simply permits, the diminution of the 1332 waiver guardrails discussed above. Permitting states to eliminate HealthCare.gov removes consumer options and instead imposes an existing and less preferable method for shopping and obtaining health insurance upon consumers.

Special Enrollment Period for People with Low Incomes

The proposed rule would establish a new SEP for individuals and dependents who are eligible for APTCs with a household income under 150% of the federal poverty level (FPL). The SEP would allow those eligible to enroll at any point during the year based on their income or upon learning of their eligibility. We strongly support this proposal and are confident that this SEP will provide more opportunities for certain people with lower incomes to access \$0 or very low-cost premium health care.

Almost all patients report experiencing barriers in accessing care, regardless of their income level, location, and health plan. Cancer patients with lower incomes are particularly at risk as they face barriers in qualifying for, accessing, and maintaining health care coverage for essential services. Evidence shows that many people who are uninsured have not enrolled in health coverage because they are unaware of their various options or because the cost of coverage is too high. According to the Congressional Budget Office, of the 31.5 million people uninsured in 2021, more than one-third of people who are uninsured are eligible for Medicaid or for APTCs in the Marketplace (CBO, 2020). An estimated 1.3 million of these individuals have incomes below 150% of the FPL (Rae et al., 2021).

Combined with robust outreach and engagement efforts, the SEP will help to boost enrollment, reduce the number of people who are uninsured, and provide people with low incomes the care and services that they need at a low cost.

User Fee Rates for the 2022 Benefit Year

We [strongly opposed](#) the significant cuts proposed to user fees on the FFE and the SBE-FP in the 2022 NBPP. These fees, collected from insurers, support the services provided by HealthCare.gov to assist cancer patients and other consumers secure information and enroll in health care (Forsberg, 2018). We were concerned that the proposed cuts would seriously undermine the ability of states to provide these necessary services and act as a funnel to lead states to web-brokers and the privatization of the exchanges.

HHS has reanalyzed the potential impacts of the user fee reduction on states and the individuals and families who rely on them and propose to increase the FFE user fee rate to 2.75% of premiums and the SBE-FP user fee rate to 2.25% of premiums.

Network Adequacy

We appreciate that CMS is requesting input regarding how the federal government should approach network adequacy standards for plans offered through the FFE. Marketplace health plans are required by federal law to maintain an adequate network of providers and up-to-date online provider directories to help ensure that marketplace enrollees have accurate information to enable them to identify the plans and providers most likely to meet the care and services they need.

As you address the network adequacy review process, we urge CMS to review standards through a health equity lens, to ensure that all people impacted by cancer have timely access to the health care they need, no matter their race, ethnicity, gender, age, sexual orientation, socioeconomic status, or zip code. Networks should be evaluated whether the provider network is sufficient to deliver culturally competent, anti-bias care to meet the needs of diverse enrollee populations, including people of color, people with limited English proficiency, people with disabilities, and LGBTQ+ individuals.

We also recommend that provider directories be available in languages in addition to English to enable consumers to identify the health care plans and providers to meet their health care needs.

Conclusion

Thank you again for the opportunity to provide comments on the proposed rule. Should you have any questions, please contact Phylicia L. Woods, Executive Director of the Cancer Policy Institute at the Cancer Support Community at pwoods@cancersupportcommunity.org.

Sincerely,



Phylicia L. Woods, JD, MSW
Executive Director – Cancer Policy Institute
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