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July 28, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulatoins.gov

RE: 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—AHIP Comments

Dear Administrator Brooks-LaSure:

On behalf of AHIP, thank you for the opportunity to provide comments in response to the Department of Health and Human Services (HHS) proposed rule on Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, published in the *Federal Register* on July 1, 2021 (86 FR 35156).

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. We believe that when people get covered and get and stay healthy, we all do better. The best way to do that is to expand on the market-based solutions and public-private partnerships that are proven successes.

We applaud the Administration and Congress for taking significant steps to make coverage more affordable and expand enrollment in the Affordable Care Act's individual market. More Americans can access affordable coverage as a result of the expanded eligibility for advance payments of premium tax credit (APTC) under the American Rescue Plan Act (ARPA), the ongoing 2021 Marketplace special enrollment period (SEP), and the Department's increased funding to support robust outreach, education, and the Navigator program. Enrollment gains under the ongoing SEP—over 2 million enrollees as of June—demonstrate the impact of expanded APTC eligibility and increased investment in outreach, education, and marketing. We appreciate the Department's focus on reaching traditionally uninsured and underinsured consumers and encourage HHS to continue these efforts in future open enrollment periods.

The ACA's health insurance exchanges are strong and continue to grow and it is critical that this important progress is maintained. Competition among health insurance providers continues to increase, which led to lower premiums. Enrollees with access to two or more issuers increased from 71 percent to 96 percent in 2021 in Healthcare.gov states and more than three-quarters of enrollees have access to at least three issuers.¹

¹ CMS. Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf>

Enrollment in the health insurance exchanges continues to grow. As of February 2021, 11.3 million people are enrolled in coverage through the ACA's health insurance exchanges.² Enrollment continues to grow through the ongoing SEP—including over 1.5 million enrollees in the 36 states that rely on Healthcare.gov and over 600,000 in states that run their own exchanges, as of June 30—and we expect these figures will continue to climb through the end of the SEP on August 15.³

Health insurance providers remain committed to ensuring all Americans have access to affordable, high-quality health care and we support the Department efforts to advance policies that will achieve this goal. We appreciate the Administration's commitment to strengthening the individual market, ensuring availability of affordable coverage, and removing barriers to care. It is critical that policies intended to expand enrollment do so in a manner that protects the stability of the individual market.

Our comments aim to build on the successes of the ACA to further expand access to affordable coverage in a manner that strikes an appropriate balance between promoting enrollment and avoiding policies that could undermine risk pool stability and lead to fewer options and higher premiums. Specifically, our detailed comments on the proposed rule include:

- **Annual Open Enrollment Period:** We recommend the Department maintain the annual open enrollment deadline of December 15. HHS should codify policies that encourage consumers to enroll in comprehensive coverage for the full plan year. Changes to the enrollment deadline could disincentivize consumers from enrolling in time for January 1 coverage, which could be harmful to consumers' health and financial stability. Further, consumers need consistency and predictability in deadlines. Changing the deadline to January 15 could create confusion that impacts consumers' ability to enroll in coverage for January 1. We understand the Department's concern for consumers who are automatically reenrolled and experience an increase in premium. We believe a targeted SEP for consumers who automatically reenroll and experience an increase in premium is a better alternative than extending the open enrollment period because of less risk for adverse selection.
- **Low-Income Monthly SEP:** We do not support the proposed monthly SEP for APTC-eligible consumers who have household incomes under 150 percent federal poverty level (FPL). The Department proposes this monthly SEP to facilitate enrollment for people who disenroll from Medicaid, particularly those expected to lose Medicaid coverage at the end of the COVID-19 public health emergency (PHE). HHS should implement policies that encourage consumers to enroll in and maintain continuous coverage. Permitting consumers to enroll at any time during the plan year, or change plan selections on a monthly basis, could have significant adverse consequences for the individual market. We anticipate consumers would enroll in coverage at the point of care and or change plans mid-year. Constant enrollments and disenrollments would undermine stability of the individual market and could result in higher premiums, narrower networks, and limit consumer choice. Monthly switching could also result in higher out-of-pocket costs for consumers and disruptions in care. We strongly urge the Department to not finalize the proposed monthly SEP. Instead, HHS, state Medicaid programs, issuers, and other enrollment assisters should undertake additional outreach and education efforts to reach individuals who

² CMS. New HHS Data Show More Americans than Ever Have Health Coverage through the Affordable Care Act. June 5, 2021. <https://www.cms.gov/newsroom/press-releases/new-hhs-data-show-more-americans-ever-have-health-coverage-through-affordable-care-act>

³ CMS. Health Care Sign Ups Surpass 2 million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline. July 14, 2021. <https://www.cms.gov/newsroom/press-releases/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-aug-15-deadline>

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disenroll from Medicaid and, if eligible, submit an application for and enroll in subsidized coverage through the Exchange using the existing SEP for loss of minimum essential coverage (MEC).

- **Exchange Direct Enrollment Option:** We strongly support the Department's proposal to remove the Exchange Direct Enrollment option, finalized under the first 2022 Payment Notice final rule in January, which would allow states to adopt a decentralized exchange. We continue to have concerns that a decentralized exchange would undermine consumers' abilities to access reliable, accurate information on all available qualified health plans (QHPs) before enrolling in coverage. We agree this option would undermine the Administration's commitment to removing barriers to coverage and recommend it be removed.
- **User Fees:** We recommend the Department finalize the 2022 user fees as proposed. For future plan years, we recommend HHS consider alternative methodologies to fund exchange operations activities. Specifically, we recommend HHS assess the impact of transitioning to a per member per month user fee. We believe this approach could support the Federal exchange's operations by more appropriately tying fees to increases enrollment rather than increases in medical trend. This approach would align with the Department's increased commitment to reaching uninsured individuals and expanding enrollment in the exchanges.
- **1332 Waiver Guidance:** We support rescinding the 1332 waiver guidance codified in the 2022 Payment Notice final rule and reverting to the previous 1332 waiver guidance. We appreciate HHS' commitment to providing states flexibility to implement solutions to improve the individual market through 1332 waivers and will continue to work with HHS and states to identify policies that promote competition, affordability, and stability.
- **Segregation of Funds:** We strongly support the Department's proposal to remove burdensome requirements that QHP issuers offering coverage of non-Hyde services send separate monthly bills and collect separate payments for these services. This requirement would have generated unnecessary operations costs and caused consumer confusion that would have created a potential barrier to maintaining coverage. We strongly support codifying guidance from the 2016 Payment Notice preamble to provide QHP issuers options to meet the ACA's requirement for segregation of funds without placing burdens on consumers or creating unnecessary new costs.

We provide detailed comments on these and other provisions of the proposed rule in the attachment. We appreciate the opportunity to offer comments on the proposed rule and look forward to continue working with the Department to develop and implement policies that will expand access to affordable coverage.

Sincerely,

A handwritten signature in cursive script that reads "Jeanette Thornton". The signature is written in black ink and is positioned above the typed name and title.

Jeanette Thornton
Senior Vice President, Product, Employer, and Commercial Policy

AHIP Comments on Updating Payment Parameters Proposed Rule

AHIP's comments on the proposed rule are organized into the following sections:

- I. Part 155—Exchange Establishment Standards
- II. Part 156—Health Insurance Issuer Standards
- III. 1332 Waiver Guidance
- IV. Requests for Information for Future Rulemaking

I. Part 155—Exchange Establishment Standards and Other Related Standards under the ACA

A. Navigator Program Standards (§ 155.210)

The Department proposes to amend § 155.210(e)(9) and reinstitute the requirement that Navigators in FFEs provide consumers relevant information and assistance for certain post-enrollment topics—including filing eligibility appeals, applying for exemptions, assisting with premium tax credit reconciliation, providing basic concepts and rights related to healthcare coverage, and referrals to tax preparers and tax resources—to help consumers navigate enrollment, coverage, and meet obligations related to coverage and subsidies.

Recommendations:

- **We support the Department's decision to once again require Navigators to assist enrollees with certain post-enrollment activities instead of just authorizing them to do so.** Navigators can play an important role during the enrollment process, helping consumers by understanding the rules and regulations around the enrollment process, including plan selection and tax reconciliation process. These can be complex processes for consumers. Consumers may face additional challenges after completing an application and plan selection, such as filing an eligibility appeal, accessing IRS tax resources to reconcile tax credits, and basic principles related to using their health insurance coverage, especially if they were recently uninsured. Requiring Navigators to provide this support will provide consumers additional resources to help the complete enrollment-related processes like filing an appeal or reconciling tax credits to maintain coverage.
- **The Department should consider expanding Navigator responsibilities to include facilitating transitions between Medicaid and the Exchange for consumers whose eligibility changes due to a change in income.** In the preamble of the proposed rule, HHS raises concerns about the potentially large volume of individuals who will be disenrolled from Medicaid at the end of the COVID-19 public health emergency and the potential. Navigator responsibilities should be expanded to include coordination with State Medicaid programs to identify individuals who are disenrolled from Medicaid and help them complete an Exchange eligibility application to avoid gaps in coverage.
- **We recommend that the Department issue a report to examine the successes and outcomes of the Navigator program.** HHS should conduct an analysis and produce a public report on the success of the Navigator program, including specific data on the number of enrollments supported, demographics of populations who most benefit from Navigator support, and utilization of additional post-enrollment services. We strongly support the Administration's commitment to consumer outreach and education, including a renewed investment in the Navigator program. The

recently announced \$80 million funding opportunity for Navigators in FFE states for plan year 2022 is the largest funding allocation for the Navigator program to date. A public report to demonstrate the impact of these funds in supporting enrollments, particularly for traditionally uninsured or underinsured populations, would demonstrate the value of the program or highlight areas for improvement in allocating Navigator funding to drive enrollment. We also recommend the Department consider requiring a performance evaluation every three years instead of two years to align the full scope of a grantee with their award to ensure quality and transparency.

B. Exchange Direct Enrollment Option (§ 155.221(j))

The Department proposes to repeal the Exchange Direct Enrollment (DE) option, and the associated user fee, established in Part 1 of the 2022 Payment Notice final rule, citing changes in administration policy and operational priorities, enactment of new federal laws, and lack of state interest.

Recommendation:

- **We support the Department’s proposal to repeal the Exchange DE option, as well as the associated 1.5 percent user fee.** We previously raised concerns about the Exchange DE option because it would have allowed states to move away from a centralized Exchange website and instead rely exclusively on third-party websites to support plan shopping, eligibility determinations, and plan selection and enrollment. A decentralized Exchange framework would negatively impact a consumer’s ability to access reliable, accurate, and consistent information when comparing coverage options, seeking eligibility determinations, and enrolling in a QHP through the Exchange. Providing states the option to adopt a decentralized exchange would make it difficult for consumers to compare plans in an apples-to-apples approach to determine what works best for their needs.
- **We agree the Exchange DE option is inconsistent with the Administration’s policies outlined in Executive Orders 13985 and 14009, including the commitment to successful implementation of the Health Insurance Marketplaces and lowering barriers to coverage.** A decentralized Exchange would make it more difficult for states to consistently and accurately implement changes such as the current 2021 Marketplace SEP and American Rescue Plan tax credits. The Exchange DE option would undermine a “No Wrong Door” approach to enrollment, taking a step backward from providing a comprehensive, streamlined approach to shopping for coverage, making a plan selection, completing an application, and enrolling in coverage. Additionally, HHS and states that run their own exchanges have made significant financial and operational investments to ensure seamless consumer enrollment experiences and smooth back-end processes to support plan selection, eligibility applications, enrollment, and post-enrollment updates. Providing states the option to decentralize the exchange would undercut these significant investments. We support the Department’s proposal to remove § 155.221(j) and repeal this option, as well as the related user fee.
- **We continue to strongly support the existing Enhanced Direct Enrollment (EDE) as a valuable channel for consumers to compare plan options, complete an eligibility application, and enroll in coverage.** EDE model provides another tool for consumers to use when shopping for coverage in addition to the centralized Exchange websites. EDE is an example of a successful public-private partnership that was built and strengthened over two Administrations. The Department has collaborated closely with issuers to develop, implement, and iteratively improve the EDE as an additional enrollment channel to support consumers during open enrollment and with SEPs. EDE facilitates a growing number of enrollments every year. The EDE pathway more than doubled the number of consumers who selected a plan, from 521,000 to 1.13 million, during the 2021 OE period, which represented 17 percent of active plan selections. Additionally,

425,000 enrollees made an active plan selection across EDE and Classic DE combined during 2021 OE—a 38 percent increase over 2020 open enrollment. AHIP member QHP issuers remain committed to further strengthening this program so that all “doors” to Exchange coverage provide consumers with a reliable, impartial end-to-end enrollment experience.

- **We are committed to ensuring EDE websites provide consumers a robust, reliable, consistent enrollment experience.** Issuers who offer EDE are committed to providing consumers a seamless, reliable enrollment experience through this channel and must meet rigorous standards related to website requirements, eligibility questions and determinations, QHP display requirements, and compliance with privacy and security standards. We are aware some stakeholders have previously raised concerns that some web-broker EDE websites may display options in a way that could mislead consumers into enrolling in coverage that is not eligible for subsidies or non-ACA compliant. We supported the additional QHP display requirements, adopted in the second 2022 Payment Notice final rule, to establish more clear guardrails around how APTC-eligible QHPs, off-exchange QHPs, and non-ACA compliant products are displayed to minimize opportunities for consumer confusion that could result in unintentionally enrolling in a different product than the consumer was seeking. We support HHS in continuing to monitor EDE websites to ensure the recently adopted guardrails provide appropriate protections for consumers.

C. Open Enrollment Period Extension (§ 155.410(e))

The Department proposes to amend § 155.410(e) extend the open enrollment period for the 2022 coverage year and beyond for all Exchanges, including SBEs. The new open enrollment period would run from November 1 to January 15, instead of November 1 to December 15. HHS specifically proposes this change to provide additional time for consumers who are automatically reenrolled but experience an increase in out-of-pocket premium owed due to a change in second-lowest cost silver plan premium. The Department seeks comment on this proposal and whether there are any viable alternative approaches that would still satisfy the goal of protecting consumers from price changes.

Recommendations:

- **We recommend HHS maintain the current open enrollment period dates of November 1 through December 15 to avoid consumer confusion and incentivize all consumers to enroll for coverage effective January 1.** We share the Department’s concerns, expressed in the preamble, that changing the open enrollment dates could cause uncertainty and reduce the number of consumers enrolled in a full year of coverage. After several years of consistent open enrollment dates, consumers are familiar with the December 15 deadline, and we agree consistency in these dates provides needed stability and predictability for consumers. Like HHS, QHP issuers observed consumer confusion in previous years when the open enrollment related to multiple deadlines (i.e., with December 15 as the deadline for January 1 coverage and a later “final” enrollment deadline resulting in coverage February 1). A single enrollment deadline creates a consistent message and allows issuers, agents and brokers, and other enrollment assisters to reinforce the deadline through streamlined messaging. Further, if open enrollment is extended, many consumers may delay enrollment until after December 15, resulting in a coverage effective date of February 1. This could result in consumers experiencing a gap in coverage or create new costs with increased consumers changing coverage in January (e.g., ID cards, enrollment packets). Extending the open enrollment period could disincentivize consumers from enrolling in comprehensive coverage for a full 12 months and place consumers at risk for disruptions in care or financial liability if they experience a gap in coverage.

- **We recommend continued improvements to notices, outreach, and education to ensure all current enrollees understand changes to their premium tax credit, out-of-pocket premium, and benefits to ensure consumers can make an informed decision when renewing coverage.** The Department specifically raises concerns about subsidized enrollees who are automatically reenrolled in an area where the second lowest cost silver plan premium decreases, resulting in lower premium tax credits and higher out-of-pocket premium. We believe enhanced noticing and special outreach to this population, as suggested in the preamble, would provide more targeted support to these consumers, and address the root cause of the problem. The timing for the batch auto-reenrollment (BAR) process results in many consumers receiving inaccurate and potentially misleading information about their premium tax credit eligibility and out-of-pocket premium in renewal notices. Issuers have implemented multiple strategies to counteract this potential misinformation, such as: advising enrollees through renewal notices and cover letters that their premium could change and they should return to the exchange for their accurate premium amount; sending January billing statements in early to mid-December so consumers see their updated premium amount before the open enrollment deadline; and targeted outreach to impacted enrollees throughout open enrollment. However, consumers may still opt to automatically reenroll without returning to the exchange to check their updated premium amount. That is why we are so committed to continuing to work with HHS to ensure issuers receive updated premium tax credit information in time to include accurate premiums in renewal notices and eliminate the potential for confusion about premiums upon renewal.
- **HHS should continue to work with issuers to identify creative solutions that would reduce consumer confusion about their APTC upon renewal.** We believe there are available options that would get accurate information in renewal notices for most, if not all, current enrollees. For example, sending BAR files before QHP certification is complete would allow most issuers to include accurate APTC and premium information in renewal notices. If any changes to plans or rates occur in the final stages of QHP certification, HHS could resend BAR files for the subset of impacted enrollees. Alternatively, excluding APTC amounts from issuer renewal notices altogether would eliminate inaccurate information and create a greater incentive for all current enrollees to return to the exchange to check their updated premium amount. While issuers have taken steps to mitigate the consumer-facing impact of the disconnect between BAR file timing and when issuers print and send renewal notices, pursuing creative solutions to deliver BAR files earlier would make significant progress in reducing consumer confusion.
- **The Department should conduct comprehensive outreach, education, and marketing to encourage consumers to enroll in 12 months of comprehensive coverage.** We support HHS' increased funding for outreach and education and the robust marketing campaign during the 2021 Marketplace SEP to reach uninsured Americans, especially those who are typically underserved populations. We strongly urge HHS to continue this level of robust marketing, outreach, and education during annual open enrollment and continue to find new ways to reach uninsured consumers. Further, outreach and education should emphasize the importance of enrolling in comprehensive coverage for a continuous 12 months.
- **We recommend HHS adopt a limited scope SEP for consumers who experience a significant increase in out-of-pocket premium after automatically reenrolling as an alternative to extending the open enrollment period.** HHS sought comments on whether an SEP for consumers who experience an increase in premiums as an alternative to extending open enrollment. Because we share the Department's goal of increasing open enrollment uptake, we believe a targeted SEP is a better alternative to extending the annual open enrollment period, both for individual consumers and for the individual market risk pool. A targeted SEP would achieve

the same goal of providing additional time for consumers to change their plan selection to ensure they are enrolled in affordable coverage while mitigating some of the challenges of extending the open enrollment deadline for all consumers. As stated above, we have significant concerns that extending open enrollment would result in fewer consumers enrolling in comprehensive coverage for a full 12 months. This could undermine individual consumers' health and financial security, and risk destabilizing the individual market risk pool. Rather than extending open enrollment, we recommend HHS adopt a targeted SEP for consumers who automatically reenroll and experience an increase in premium. The end of the open enrollment period, December 15, should be the triggering event for a 30-day SEP with prospective effective dates.

- **AHIP encourages the Department to maintain the current auto reenrollment processes so that consumers continue to benefit from continuous coverage and reduced burdens.** While issuers and exchanges encourage consumers to return to Healthcare.gov to update their application and confirm their plan selection, auto reenrollment remains a critical tool to help consumers maintain continuous coverage. While some auto reenrolled consumers may experience changes in their out-of-pocket premium when the SLCSP in their area changes, auto reenrollment allows many consumers to maintain enrollment in a QHP that meets their needs. The Department and issuers have made significant investments to optimize auto reenrollment. We continue to work closely with HHS to review the successes and challenges of each year's BAR process to identify opportunities to improve both the consumer experience and back-end operations. We will continue this commitment alongside HHS to ensure consumers enroll in and maintain coverage that meets their health and financial needs.

D. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income No Greater than 150 Percent of the Federal Poverty Level (§ 155.420(d)(16))

The Department proposes a new SEP for qualified individuals or enrollees who are eligible for APTC and whose household income is expected to be no greater than 150 percent FPL. The proposed SEP would allow eligible individuals to enroll in a QHP or change from one QHP to another one time per month. This SEP would be available at the option of the Exchange and, if finalized, would be implemented for Healthcare.gov states.

Recommendations:

- **We do not support the proposed SEP as we have significant concerns it would create instability in the individual market and result in higher premiums for all enrollees.** The proposed SEP would allow APTC-eligible individuals with incomes under 150 percent FPL to enroll in or change plans on a monthly basis. Despite guardrails proposed by HHS, including metal level restrictions, we have significant concerns this would create a revolving door of enrollment, result in adverse selection, and lead to higher premiums and fewer plan options. We are particularly concerned about adverse selection driven by monthly switching—even if metal level restrictions are applied—as well as the opportunity for providers to steer consumers to enroll in a specific plan or network at the point of care. While HHS estimates the proposed SEP would result in premium increases of 0.5 - 2.0 percent, we believe this underestimates the likely effect on premiums. Year over year the individual market continues to stabilize, and we are concerned that stability could be jeopardized if consumers are able to enroll or switch plans at any time during the year. Issuers have already experienced significant churn among subsidized populations with enrollees seeking access to certain providers or centers of excellence and this would be exacerbated by a monthly SEP. As proposed, this SEP would lead to higher rates of churn for eligible individuals and potential provider gaming. The resulting adverse selection, and competitive disequilibrium could impact premiums, result in narrowing of networks, and less choices for consumers.

- **We share the Department’s commitment to ensuring eligible individuals enroll in coverage, however this should be achieved through increased education, outreach, and enrollment support rather than a new SEP.** We understand HHS’ concern about the potentially large volume of consumers who could be disenrolled from Medicaid at the end of the public health emergency (PHE) and agree that HHS, states, issuers, and Exchanges should prioritize outreach to this population to help eligible individuals enroll in Exchange coverage. Several existing SEPs provide opportunities for eligible individuals to enroll in subsidized coverage mid-plan year, including loss of minimum essential coverage, which includes loss of Medicaid coverage. Additionally, if an individual is unaware that loss of Medicaid is a qualifying event and misses the SEP window, the Department recently codified a new SEP to provide a 60-day SEP. Ensuring eligible consumers are aware of enrollment opportunities and providing application and enrollment assistance are especially important for this population. State Medicaid programs, Exchanges, Medicaid managed care issuers, QHP issuers, and other state programs should engage in a robust outreach efforts to ensure individuals who disenroll from Medicaid, especially those who will lose eligibility at the end of the PHE, are aware they are eligible for subsidized coverage and can access resources and support to complete an application and enroll in coverage.
- **Allowing monthly switching would expose consumers to higher out-of-pocket costs and disruptions to care.** As HHS acknowledges in the preamble, allowing consumers to change QHPs on a monthly basis could have adverse consequences. Specifically, if an eligible individual uses the SEP to switch plans, their deductible and out-of-pocket accumulators may reset, resulting in greater cost sharing over the course of the plan year than if they stay in the same plan. Further, issuers have found consumers at this income level tend to be more vulnerable and need additional support utilizing coverage and managing their health care. Frequent plan switching undermines an issuer’s ability to engage with enrollees and provide support service to help monitor and manage their health care throughout the year. Allowing low-income consumers to switch plans on a monthly basis would not benefit, and could harm, this population.
- **HHS should identify other options to help APTC-eligible consumers with incomes under 150 percent FPL enroll in and maintain coverage through the Exchanges.** For example, rather than creating a new SEP that would allow monthly switching, the Department could provide a one-time extension to the loss of MEC SEP to provide qualified individuals who are disenrolled from Medicaid at the end of the PHE. Extending the SEP to 90 days would provide this population with additional time to apply for and enroll in subsidized Exchange coverage. Issuers, states, and Exchanges would have more time to identify and work with this population and connect them with appropriate resources to enroll in coverage.
- **While we strongly oppose the proposed SEP, if the Department finalizes this policy, it should make several modifications to mitigate risks to market stability that could impact affordability and access to coverage.** Specifically, we recommend:
 - HHS should limit the SEP to APTC-eligible individuals with incomes under 150 percent FPL who are currently uninsured.
 - HHS should not allow eligible enrollees to switch plans in the middle of the plan year unless they qualify through an existing SEP. Current enrollees should be encouraged to maintain 12 months of coverage to promote market stability and avoid disruptions in coverage.
 - Eligible individuals should be limited to enrolling in 94 percent AV silver level plans.

- The SEP should not be implemented prior to January 1, 2023. Plan actuaries need sufficient time after publication of the final rule to assess the potential impact of this policy. Issuers and states are currently finalizing plan year 2022 rates and it is too late to assess the potential impact of this policy for plan year 2022 and incorporate those assumptions into premiums.
- Availability of the SEP should be aligned with enhanced subsidies available under the American Rescue Plan Act. If the ARPA subsidies are not extended or enacted permanently, the SEP should sunset.
- While we do not agree with allowing eligible enrollees to switch plans under this SEP, because it would destabilize the individual market and result in higher out-of-pocket costs for enrollees, if HHS permits switching, metal level restrictions should apply.

II. Part 156—Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

A. User Fee Rates for the 2022 Benefit Year (§ 156.50)

The Department proposes to increase the 2022 user fee rates to 2.75 percent of monthly premiums for FFE issuers and 2.25 percent for issuers in State-based Exchanges using the Federal Platform (SBE-FPs). Although these proposed user fee rates are higher than the rates finalized in Part 1 of the 2022 Payment Notice rule, the Department argues the additional costs of expanded services, such as consumer outreach in both the FFE and SBE-FPs, and Navigators in the FFE for the 2022 plan year require additional user fees.

Recommendations:

- **We recommend the Department finalize as proposed the updated user fee rates for FFE and SBE-FP issuers for plan year 2022.** AHIP supports the Department’s renewed investment in outreach, education, and marketing related to the 2021 Marketplace SEP and open enrollment period to facilitate robust enrollment for plan year 2022.
- **The Department should provide greater transparency regarding collected user fees and allocation of user fees to support Exchange operations, outreach and education, and consumer-facing activities.** Specifically, we recommend the Department conduct and release a report on the amount of user fees collected from FFE and SBE-FP issuers, and how funds are utilized to support Exchange operations. Lack of transparency into the amount of user fees collected, the amount used to support Exchanges, and which Exchange functions are supported by user fees has made it difficult for AHIP and stakeholders to provide thoughtful, detailed comments in response to proposed changes to user fee amounts and Exchange policy. A detailed report on user fees would provide needed insight into whether the current user fee methodology is able to support Exchange operations, or whether an alternative methodology would be more appropriate for future plan years.
- **We recommend the Department assess the impact of transitioning to a capitated user fee as an alternative to the current user fee methodology.** In the 2022 Payment Notice proposed rule, HHS sought input on whether it should reassess the current user fee methodology and evaluate whether an alternative methodology would better support Exchange operations. In our comments on the proposed rule, AHIP agreed with the Department’s assessment that operational costs to operate Healthcare.gov have changed since initial implementation. HHS has iteratively improved the Federal exchange to optimize the website and back-end operations. While HHS has recently renewed its commitment to funding robust outreach and education to promote new enrollments, overall operational costs should be lower than they were in the early years of Healthcare.gov. As

we have previously commented, an alternative user fee methodology should be adopted to support Exchange operations. Now is an appropriate time to reassess both the level of funding needed to support Healthcare.gov operations as well as the methodology used to assess issuers. We recommend HHS assess the impact of transitioning to a per member per month user fee rather than calculating user fee as a percent of premiums. Currently, Healthcare.gov operations are supported by a user fee calculated as a percent of premiums. Under the current approach, user fees rise with medical trend, AV calculation and plan value trend, average enrollee age, overall health of the risk pool, CSR silver loading, and other factors that increase rates. A capitated user fee methodology would instead collect funds to support FFE and SBE-FP operations as enrollment increases, creating a new set of enrollment-based incentives.

B. Segregation of Funds for Abortion Services (§ 156.280)

The Department proposes to repeal the separate billing regulations at § 156.280(e)(2)(ii), which required QHP issuers to send a separate bill for the portion of a premium attributable to coverage for non-Hyde abortion services and to instruct enrollees to pay for the separate bill through a separate transaction. HHS proposes to revert to and codify in amended regulatory text at § 156.280(e)(2)(ii), the policy in the preamble of the 2016 Payment Notice, which provided issuers flexibility to select a reasonable method to satisfy with the separate payment requirement in section 1303 of the ACA.

Recommendation:

- **AHIP strongly supports removing existing regulations that require issuers to send separate bills and separate billing and collection of premium payments and codifying policy in the 2016 Payment Notice preamble.** The separate billing and collection of separate payment requirement created unnecessary challenges for consumers. Removing this requirement is consistent with Eliminating the requirement that issuers send separate monthly invoices for the portion of premium attributable to non-Hyde premiums will reduce consumer confusion, making it easier for consumers to pay monthly premiums. Removing this requirement will eliminate costly and operationally burdensome requirement for issuers and reverting to prior guidance will provide issuers flexibility to meet the requirement of or segregation of funding without placing unnecessary burdens on consumers. We agree the methods outlined in the preamble of the 2016 Payment Notice provide appropriate options for issuers to comply with the separate payment requirement and should be codified in regulation.

III. 31 CFR Part 33 and 45 CFR Part 155—Section 1332 Waivers

Together with the Department of the Treasury, the Department proposes to generally remove the language incorporating the 2018 State Relief and Empowerment Waiver interpretation of the statutory guardrails codified in regulation in Part 1 of the 2022 Payment Notice final rule. The Departments propose new interpretations of and amendments to section 1332 waiver approval requirements, application review procedures, certain analytical requirements, operational considerations, pass-through funding calculation, and amendments and extensions of approved waiver plans.

Recommendations:

- **We support rescinding the 1332 guidance codified in the final 2022 Payment Notice and reverting to the previous 1332 guidance.** AHIP supports policies that promote choice, competition, and multiple affordable high-quality coverage options for consumers. We support federal policies that recognize the role of state regulators, and that provide flexibility for states to implement solutions to improve their insurance markets. We appreciate the Departments' actions to make it easier for states to address issues in the individual insurance markets with 1332 waivers, such as reinsurance programs which have helped thousands more Americans afford their

coverage.

- **AHIP recommends that the Departments adopt the “reasonably foreseeable” definition for emergent situations.** The Departments should adopt the definition of “reasonably foreseeable” from the preamble discussing changes to 31 CFR 33.118 and 45 CFR 155.1318. The Departments describe situations that are not emergent situations if they are “reasonably foreseeable”, including number of days, the specific circumstances involved, the nature and extent of the future emergent situation, and whether the state could have predicted the situation.

IV. Requests for Information for Future Rulemaking

A. Guaranteed Availability of Coverage (§ 147.104)

The Department has indicated it will review the interpretation of guaranteed availability, articulated in the preamble of the Market Stabilization rule, to determine whether it presents unnecessary barriers to accessing health coverage under Executive Order 14009. This policy stated issuers would not be in violation of guaranteed availability rules if, to the extent permitted by state law, the issuer attributed premium payments made for new coverage to past-due premiums for coverage under the same issuer (or issuer in the same controlled group) within the prior 12-month period before effectuating enrollment for the new policy.

Recommendations:

- **We urge HHS to maintain its current interpretation of guaranteed availability such that issuers may, to the extent permitted by state law, may adopt a past-due premium policy.** AHIP supports the Administration’s move to examine whether existing rules, regulations, policies, and procedures promote or hinder American’s access to affordable healthcare coverage. We do not believe the option for issuers to adopt a past-due premium policy creates an unnecessary barrier to care but instead provides an important guardrail to promote a stable risk pool and affordable premiums for all enrollees. The current interpretation of guaranteed availability encourages consumers to maintain continuous coverage and discourages misuse of SEPs. Removing this option would require issuers to write-off past due premiums and make it easier for consumers to move in and out of coverage. While not all issuers have adopted a past-due premium policy, removing this option would send the wrong signal to consumers, agents, and brokers. To build on stability of the individual market risk pool, HHS should implement policies that encourage continuous enrollment. Thus, urge the Department to maintain the current interpretation of guaranteed availability.

B. Standardized Plan Options (§ 155.20)

The Department has indicated, in wake of the United States District Court for the District of Maryland’s *City of Columbus v. Cochran* decision, that it plans to resume designating standardized plan options and will propose new plan designs in the 2023 Payment Notice. The Administration further signaled its intent to reinstate standardized plan options in the recent Executive Order on *Promoting Competition in the American Economy*, which directed the Secretary of Health and Human Services to “implement standardized options in the national Health Insurance Marketplace and any other appropriate mechanisms to improve competition and consumer choice.”

Recommendations:

- **In considering how to reintroduce standardized plan options in states using Healthcare.gov, we urge HHS to do so in a manner that provides meaningful options to consumers when selecting coverage options.** HHS’ stated goal is to offer options that allow consumers to

comparison shop when enrolling in coverage through Healthcare.gov. However, there are significant challenges in this approach. Standardized plan designs are only “standard” with respect to their cost-sharing. Issuers offer an array of plans with unique design features that directly impact the way in which enrollees use coverage, including networks, formularies, care management, utilization management, negotiated rates, centers of excellence, value-based design, etc. Standardized plans could be misleading to consumers by portraying plans as equivalent options when they have significant differences that will impact benefits and coverage. We urge the Department to carefully consider this foundational challenge in reintroducing standard plans and how they are displayed on Healthcare.gov. Consumers should be encouraged to consider all of these factors when making a plan selection.

- **HHS should take a similar approach as it did in previous years, offering standardized plan options that are based on the most popular plans currently offered in the exchanges and not overly prescriptive in plan design.** HHS should propose standardized plan designs that are straightforward for consumers to understand and not overly complex for issuers to develop. Standardized plan designs should not be overly complex or radically different plan designs than those offered today, which would be more complicated for issuers to develop and could be challenging for consumers to interpret. Further, we urge HHS to not be overly-prescriptive in standardizing every level of cost-sharing (i.e., defining coinsurance or copays for specific specialties), but focus instead on annual deductible and annual out-of-pocket limits. Finally, we recommend formularies not be limited to four tiers.
- **QHP issuers should have the option to offer standardized plans.** QHP issuers should not be required to offer standardized plan options and should not be limited from offering other plan designs that they believe offer value to consumers. When developing plan offerings, issuers conduct extensive research to develop innovative plans and networks that will meet the needs of the populations and communities within their service areas. Issuers should not be limited from offering innovative plan designs or plans designed to meet the needs of consumers in their service area. Further, issuers should not be required to offer standardized plan options if they do not believe they will provide value to the consumers they serve. Requiring issuers to broadly offer standardized plans could result in an influx of options that do not necessarily provide additional value to consumers and make it more difficult, rather than easier, to sort through and compare plan options. Finally, HHS should examine whether revisiting and enforcing meaningful difference standards would help ensure consumers aren't overwhelmed with an excess of similar QHPs.
- **HHS should not implement differential display of standardized plan options on Healthcare.gov.** HHS should not differentiate the display of standardized plan options or otherwise give special preference to these plans. We are concerned that a differential display would increase consumer confusion and may appear to favor some plans over others and inadvertently steer consumers or otherwise influence the shopping experience. Alternatively, Healthcare.gov could offer consumers the option to filter for standardized plans or include a pre-shopping survey to help assess whether a consumer is interested in or would benefit from comparing standard plan options.
- **We also urge HHS to share data on prior experience with standardized plan options, including the number of plans offered and enrollment in those plan options.** HHS should share an analysis of the 2017-2018 experience with standardized plans, including number of plans offered and enrollment to provide stakeholders better insight on the impact of standardized plans and whether they filled an unmet need for consumers. Further, insights from call center

representatives or enrollment assisters on whether the 2017-2018 standardized plans facilitated easier plan comparisons, as intended would offer important insight.

C. Network Adequacy (§ 156.230)

Following the United States District Court for the District of Maryland's *City of Columbus v. Cochran* decision, the Department indicated that it intends to promulgate rules proposing specific steps to address federal network adequacy as soon as possible and expects them to be addressed in time for the 2023 plan year.

Recommendations:

- **AHIP supports continued deference to state network adequacy review.** States are best suited to make network adequacy determinations, and deference to states helps reduce duplicative and unnecessary reviews. Most states already have significant network adequacy expertise and longstanding review processes that ensure that consumers have access to high-quality coverage options. In states that do not have an adequate review or insufficient resources, we support the use of existing standards – for example, an issuer's existing Medicaid or commercial accreditation or, for unaccredited issuers, an access plan consistent with the National Association of Insurance Commissioners (NAIC) Health Plan Network Access and Adequacy Model Act, which was revised through a robust, thoughtful stakeholder process to including providers, consumer groups, state regulators, and health plans.
- **AHIP opposes rigid quantitative tools to determine reasonable access.** Rigid requirements like federal time and distance standards impose unnecessary burdens on plans that do not adequately reflect unique local market dynamics. Time and distance standards provide only a narrow assessment of the breadth and accessibility of a provider network. Factors like provider quality, innovative health care delivery approaches, geographic barriers, population, provider density, or patient preference are not taken into account under these restrictive definitions. In a review of state network adequacy standards, we found that no state has only time and distance standards. The majority of states consider a broad range of standards such as provider ratios, number of facilities, wait times, hours of operation, specialty types, telehealth, accreditation, and other various exceptions to geographic standards.
- **Finally, AHIP intends to engage in a longer-term process to provide thoughtful feedback to the Department on ways to approach federal network adequacy reviews in advance of the 2023 Payment Notice.** We look forward to providing additional detailed recommendations for HHS' consideration and will work with the Department to consider appropriate, meaningful ways HHS can complement state network adequacy reviews without duplicating state efforts.