ETHICS AND PUBLIC POLICY CENTER

July 28, 2021

Via Federal eRulemaking Portal

The Honorable Xavier Becerra
Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9906–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: EPPC Scholar Comment Opposing 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 Proposed Rule," RIN 0938–AU60

Dear Secretary Becerra:

I am a scholar at the Ethics & Public Policy Center (EPPC) and write in opposition to the 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 Proposed Rule."[1] The views expressed in this Comment are my own. The first part my Comment responds to proposed regulations related to separate payments for abortion services, while the second part provides comment on the proposed rule's other provisions: Exchange Direct Enrollment option repeal, open enrollment period extension, Navigators program expansion, new monthly special enrollment period for certain low-income consumers, increased user fees for 2022, and section 1332 waivers reinterpretation. The third part discusses the insufficient 30-day public comment period for the proposed rule. For the reasons discussed below, I urge the U.S. Department of Health and Human Services (HHS or the Department) to withdraw the proposed rule from consideration.

I. Separate Payments for Abortion Services

HHS seeks comments on the proposal "to repeal the separate billing regulation and amend the regulatory text at § 156.280(e)(2)(ii) to codify the prior policy in the 2016 Payment Notice for satisfying the separate payment requirement in section 1303 of the ACA."[2] In short, as

[1] 86 Fed. Reg. 35156.
[2] *Id.* at 35179.

explained in detail below, I write in strong opposition to these proposed regulations and urge the Department to keep and defend the separate billing regulations in the 2019 "Patient Protection and Affordable Care Act; Exchange Program Integrity" Rule (Program Integrity Rule).[3]

HHS also seeks comments on a proposed "technical" change to the heading of § 156.280 to delete the phrase "separate billing" and merely state "segregation of funds for abortion services."[4] If HHS adopts the proposed separate payment regulation to remove the separate billing requirement (which I oppose), the heading should read "separate payments and segregation of funds for abortion services" to mirror the statutory text and reiterate section 1303(b)(2)'s requirement that plan issuers collect separate payments.

A. Section 1303's Text and Regulations

1. Section 1303's Separate Payment Requirement

Section 1303 of the Patient Protection and Affordable Care Act (ACA) establishes "special rules relating to coverage of abortion services."[5] Under the section, qualified health plans (QHPs) are permitted, but not required, to provide coverage of abortion services, but those that do are prohibited from using federal funds to pay for abortion services for which taxpayer dollars are restricted under the Hyde Amendment ("Hyde-restricted abortion services").[6]

As part of the prohibition on the use of federal funds, section 1303(b)(2) states that the issuer of a plan "shall[] collect from each enrollee in the plan . . . a *separate* payment for each of the following": (a) the premium amount for coverage of Hyde-restricted abortion services, and (b) the premium amount for coverage of services excluding Hyde-restricted abortion services.[7] These "separate payments" "shall" be deposited into "*separate* allocation accounts"—one for all payments for Hyde-restricted abortion services and one for all payments for other services.[8] Section 1303 also states that for enrollees whose plan premium is paid through employee payroll deposit, the separate payments listed above "shall each be paid by a *separate* deposit."[9]

During legislative debate on the ACA, the author of section 1303 Senator Ben Nelson (D-Neb.) explained that separate payment meant separate bills and separate transactions:

> [I]f you are receiving Federal assistance to buy insurance, and if that plan has any abortion coverage, the insurance company must bill you separately, and you must pay separately from your own personal funds—perhaps a credit card transaction, your separate personal check, or automatic withdrawal from your bank account—for that abortion coverage.

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[3] 84 Fed. Reg. 71674 (Dec. 27, 2019).
[4] 86 Fed. Reg. 35177.
[5] 42 U.S.C. § 18023(b).
[6] *Id.* § 18023(b)(1).
[7] *Id.* § 18023(b)(2)(B)(i) (emphasis added).
[8] *Id.* § 18023(b)(2)(B)(ii) (emphasis added).
[9] *Id.* (emphasis added).

> Now, let me say that again. You have to write two checks: one for the basic policy and one for the additional coverage for abortion. The latter has to be entirely from personal funds.[10]

Congress allowed QHPs on the exchanges to cover Hyde-restricted abortions, but only on condition that such plans would be subject to specific requirements regarding transparency and separation of funds, including separate payments and accounts.

2. 2016 Separate Payment Guidance

Despite section 1303's clear separation requirements, a 2014 Government Accountability Office report found that many QHP issuers were not following the law.[11] The report revealed that issuers were failing to provide notice to enrollees regarding abortion coverage, were charging less than the statutorily required minimum dollar amount for abortion coverage and were not collecting separate payments for Hyde-restricted abortion services.

Instead of addressing this noncompliance, HHS under the Obama administration enabled noncompliance by ignoring the text and purpose of section 1303. The preamble to HHS's 2016 Payment Notice identified three methods an issuer could use to satisfy section 1303's separate payment requirement, two of which did not actually require separate payments.[12] The preamble stated that an issuer could satisfy section 1303 if it sends the enrollee: (a) "a single monthly invoice or bill that separately itemizes the premium amount" for coverage of Hyde-restricted abortion services; (b) "a separate monthly bill for these services"; or (c) "a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services and specify the charge."[13] Because many plans chose the most opaque billing options offered by HHS (namely, (a) and (c)) that did not require a separate payment, many Americans were unaware they were paying a surcharge for abortion coverage or had abortion coverage at all, including for family plans.

3. 2019 Separate Billing Regulations

In 2018, nearly 100 members of Congress sent a letter to HHS pointing out that the Department's interpretation of section 1303 "negate[d] the clear meaning of the statute's phrase, 'separate payment,'" and asking HHS to issue new regulations that "align with the clear meaning and legislative history of Section 1303."[14] HHS reevaluated the 2016 guidance, concluding that it did not adequately reflect the text and purpose of section 1303—namely, section 1303 mandated that "issuers collect two distinct (that is, 'separate') payments, one for the coverage of [Hyde-restricted] abortion services, and one for coverage of all other services covered under the

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[10] 155 Cong. Rec. S14134 (Dec. 24, 2009), https://www.congress.gov/111/crec/2009/12/24/CREC-2009-12-24-pt1-PgS14132.pdf.

[11] *See* U.S. GOV'T ACCOUNTABILITY OFFICE, HEALTH INSURANCE EXCHANGES: COVERAGE OF NON-EXCEPTED ABORTION SERVICES BY QUALIFIED HEALTH PLANS (Sept. 15, 2014), http://www.gao.gov/products/GAO-14-742R.

[12] 80 Fed. Reg. 10749.

[13] *Id.* at 10840.

[14] Letter from Christopher H. Smith, Member of Congress to the Honorable Alex Azar, Secretary, U.S. Dept. of Health and Human Services (Aug. 6, 2018), *available at* https://chrissmith.house.gov/uploadedfiles/2018-08-06_-_smith_letter_on_section_1303_-_abortion_funding_transparency.pdf.

policy."[15] As such, HHS issued the 2019 Program Integrity Rule requiring issuers to send "an entirely separate monthly bill" to the enrollee for only the premium amount for coverage of Hyde-restricted abortion services and instruct the enrollee to pay that amount "in a separate transaction from any payment" made for coverage of other services.[16]

In response to concerns in public comments over increased costs associated with separate billing, the regulations allowed separate paper bills to be mailed in the same envelope or mailing to eliminate additional mailing costs.[17] Electronic bills were still required to be sent in separate electronic communications.[18] To address concerns over potential loss of consumer coverage for non-compliance with the rule which is for the benefit of enrollees, HHS directed that if the policy holder pays in a combined (instead of separate) transaction, the issuer may not refuse the payment or terminate insurance coverage on that basis.[19]

Allowing separate bills to be mailed in the same envelope and prohibiting the cancelation of coverage based solely on the policy holder's failure to make a separate payment are practical regulations that addressed concerns raised in the public comments for the benefit of enrollees. The fact that HHS granted this pro-consumer accommodation cannot be now used by HHS to support its proposed rule which harms consumers by obfuscating the reality of their paying for abortion.

The 2019 Program Integrity Rule was challenged in three federal district courts, including by Planned Parenthood and a coalition of states led by you, Secretary Becerra, when you were California's attorney general. In April 2020, a district court in Washington found that the separate billing regulations conflicted with a Washington State "Single-Invoice Statute"[20] that required health issuers to bill enrollees using a single invoice and enjoined the regulations within the state.[21] The other two district courts, one in California and one in Maryland, each issued nationwide injunctions in July 2020,[22] with both holding that the regulations were arbitrary and capricious under the Administrative Procedure Act and one holding that they were contrary to section 1554 of the ACA (which prohibits regulations that create "any unreasonable barriers" to obtaining "appropriate medical care" or impede "timely access to health care services").[23] HHS appealed all three decisions, but the cases were put on hold with the change in administrations.

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[15] 84 Fed. Reg. 71684.
[16] *Id.* at 71696.
[17] *Id.* at 71685.
[18] *Id.*
[19] *Id.*
[20] WASH. REV. CODE § 48.43.074 (Qualified health plans—Single invoice billing—Certification of compliance required in the segregation plan for premium amounts attributable to coverage of abortion services).
[21] *Washington v. Azar*, 461 F. Supp. 3d 1016 (E.D. Wash. 2020).
[22] *California v. U.S. Dep't of Health & Hum. Servs*., 473 F. Supp. 3d 992 (N.D. Cal. July 20, 2020); *Planned Parenthood of Md., Inc. v. Azar*, No. CV CCB-20-00361 (D. Md. July 10, 2020).
[23] 42 U.S.C. § 18114.

4. Proposed Regulations

Instead of continuing to defend the 2019 Program Integrity Rule, HHS is proposing to eliminate the separate billing requirement in § 156.280(e)(2)(ii) and replace it with the three methods identified in the 2016 guidance (adopting nearly identical language). The proposed regulation would state:

> An issuer will be considered to satisfy the [separate payment obligation] if it sends the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of [Hyde-restricted abortion services]; sends the policy holder a separate monthly bill for these services; or sends the policy holder a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services, and specifies the charge.[24]

While the second method is similar to the existing separate billing regulations, the first and third methods, as explained below, are contrary to law and arbitrary and capricious, and should not be adopted.

B. Proposed Regulations Are Contrary to Section 1303's Text

HHS's proposed separate payments regulations are contrary to law. They violate section 1303's text and blatantly disregard Congress' direction.

Ordinary meaning. Pursuant to section 1303, three things must be "separate": payments, allocation accounts, and deposits from employee payroll. The Merriam-Webster Dictionary defines "separate" as "set or kept apart" or "not shared with another."[25] Something that is combined cannot be "separate" by definition. "Separate" does not mean "together." It is illogical for HHS to claim that its first proposed method, an itemized bill and a single, combined payment, satisfies the separate payment requirement. A combined payment is not a separate payment. Likewise, a mere notification of a charge is not a separate payment.

Consistent usage. HHS fails to explain why "separate" should be interpreted differently in section 1303 for "payments" than for "allocation accounts" and "deposits." Nothing in the text supports interpreting "separate" differently. Indeed, if a single or combined payment is, in fact, a "separate payment," then a single or combined account could also be considered a "separate allocation account" and a single or combined employee payroll deposit could be considered a "separate deposit." But HHS correctly does not make such an absurd suggestion. To interpret "separate" differently in section 1303 when it comes to payments is contrary to the text and arbitrary and capricious.

Surplusage. If all that section 1303 requires is segregation of funds in separate allocation accounts (assuming "separate" means "distinct" for purposes of the accounts), there would be no need to include 1303(b)(2)(B)(i) regarding collection of separate payments. To avoid reading

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[24] 86 Fed. Reg. 35216.

[25] Separate, *Merriam-Webster Dictionary*, https://www.merriam-webster.com/dictionary/separate (last accessed July 27, 2021).

1303(b)(2)(B)(i) as superfluous, it must add a requirement in addition to the establishment of separate allocation accounts detailed in 1303(b)(2)(B)(ii) and 1303(b)(2)(C). The requirement in 1303(b)(2)(B)(i) is that separate or distinct payments must be collected by issuers. Likewise, "separate" modifying payments must mean something. If a single or combined payment are permitted forms of payments, the word "separate" modifying payment would be superfluous.

Lack of specified method. In support of the three proposed methods, HHS states that "section 1303 of the ACA does not specify the method a QHP issuer must use to comply with the separate payment requirement under section 1303(b)(2)(B)(i) of the ACA."[26] While this statement is technically true, it is irrelevant because the lack of specified methods in section 1303 does nothing to support HHS's faulty proposed methods. Section 1303 requires "separate payments," and any method allowing collection of separate payments would comply with section 1303. But any method not requiring separate payments—such as the proposed combined payment or notice—is not a method that complies the section. HHS is not permitted to make policy decisions or regulations contrary to Congress' direction. HHS should not repeat the mistakes it made with the 2016 Payment Notice.

HHS states that section 1303 does not "require that issuers must satisfy these requirements by separately billing policy holders or instructing them to pay in separate transactions."[27] But pursuant to section 1303, issuers "shall … collect … separate payment[s]."[28] HHS's 2019 Program Integrity Rule correctly concluded that there would be no separate payments without separate billing and "that the statute contemplates issuers billing separately for coverage of [Hyde-restricted] abortion services."[29] As such, separate billing is not just permissible, but necessary, under section 1303 for issuers to comply with the separate payment requirement. Therefore, what HHS cannot do is what it is proposing to do—allowing methods that do not comply with section 1303's separate payment requirement. HHS's proposed first and third methods should not be adopted.

HHS claims that issuers under the proposed regulations would "again have flexibility in selecting a method to comply with the separate payment requirement in section 1303."[30] But HHS is not permitted to grant flexibility contrary to express provision of the law. Even though greater transparency on abortion billing is the best policy, whether HHS, issuers, or other stakeholders disagree, Congress made the choice and embedded it in law. Separate payments cannot be redefined to mean distinct payments.

Similar to the existing requirement in section ii(B), I suggest that the regulations explicitly require issuers to instruct the policy holder to make separate payments—one for Hyde-restricted abortion services and another for all other services.

Legislative history. The statutory text is clear, and so too is legislative history. For example, the above statement by section 1303 author Senator Nelson clearly states that "separate

[26] 86 Fed. Reg. 35176.
[27] *Id.* at 35179.
[28] 42 U.S.C. § 18023(b)(2)(B)(i).
[29] 84 Fed. Reg. 71685.
[30] 86 Fed. Reg. 35158.

payments" are two distinct payments or separate transactions. HHS has yet to propose a method other than separate billing that still allows issuers to collect separate payments.

C. HHS's Justifications for Its Proposed Regulations Are Arbitrary and Capricious

The Department's justifications for its proposed changes are arbitrary and capricious. HHS cites four reasons: (a) "the substantial anticipated burden from the separate billing regulation," (b) "the risk of inadvertent coverage terminations that could result from consumer confusion due to receiving two monthly bills," (c) "the stakeholder reliance on the prior acceptable methods," and (d) "federal district court concerns with barriers to appropriate and timely medical care as well as a lack of corresponding benefits."[31] I address each in turn below.

1. Burden from Separate Billing

HHS states that it "reassessed the value of the separate billing policy and no longer believe it is justified in light of the high burden it would impose on issuers, states, Exchanges, and consumers."[32] However, HHS ignores the issuers, states, Exchanges, and consumers for which the regulations from 2019 had no impact. For example, the regulations had no effect on issuers, states, Exchanges, and consumers in states which prohibit insurance coverage of abortion services. Likewise, it had no effect on issuers that do not include such coverage for economic or moral reason. And it certainly did not create a burden on consumers who are morally opposed to the taking of human life through abortion. Indeed, such consumers have likely been the biggest beneficiaries of the billing transparency which would be rolled back by the proposed rule. But HHS arbitrarily and capriciously (and fatally) fails to quantify and account for how many people morally opposed to abortion will unwittingly end up paying for abortion coverage due to the proposed obfuscation of billing in the proposed rule.

For the burden on issuers, states, and Exchanges, there would be time and cost burdens involved with the initial setup of the separate billing process, but that is a necessary burden to comply with section 1303 and HHS does not properly calculate how many issuers have already made the changes to comply with the 2019 Program Integrity Rule or the plain text of the statute. HHS cannot credit against the regulations, burdens necessary to ensure basic compliance with section 1303. Presumably, there are significant costs associated with determining the actuarial value of the premium attributable to Hyde-restricted abortions and maintaining separate allocation accounts. Yet, that is what is required by section 1303 and any time or cost burden imposed is not a sufficient basis to change those requirements. Likewise, separate payments are also required, and any time or costs associated with collecting separate payments are not a sufficient basis for HHS to ignore section 1303's separate payment requirement. To mitigate the burden associated with increased mailing costs, the 2019 Program Integrity Rule allows issuers to mail the separate bills in the same envelope.[33] To say the 2019 regulations which allowed separate bills in the same envelope imposed a "high" burden on one of the most deeply regulated industries on the planet is grossly misleading. Insurers are giant corporations with highly sophisticated billing operations that account for tiny nuances in state law, Medicaid billing,

[31] *Id.* at 35179.
[32] *Id.* at 35177.
[33] 45 C.F.R. § 156.280(e)(2)(ii)(A).

HIPAA, and language access regulations among dozens of others. To say the 2019 Program Integrity Rule is highly burdensome to insurers is absurd.

As far as any burdens associated with record keeping and compliance, those are necessary to ensure segregation of funds under section 1303 and issuers are already required to track the separate payments and place the correct payment amount in separate allocation accounts. HHS does not explain how separate billing will create a high burden in addition to the existing record keeping and compliance burden. Indeed, collecting separate payments will make it easier for issuers to place the correct payment amount in the appropriate separate allocation accounts and minimize the need to disaggregate the funds from a combined payment.

As far as any burden on consumers, there would be the minimal amount of time it takes to understand there are separate bills that require payment in separate transactions and make a second credit card transaction, write a second check, or set up a second automatic bank withdrawal. HHS anticipates that the costs associated with separate billing would lead to increased premium rates for enrollees but provides no credible evidence in support. Further, in the proposed rule, HHS proposed increasing user fees for the 2022 plan year—which, unlike separate payments, are not required by statute—that it admits "could increase premiums for consumers."[34] HHS's inconsistent rationale it arbitrary and capricious. To the extent that HHS chooses to increase user fees, those additional funds could be used to subsidize the costs associated with separate billing.

In short, the alleged burdens associated with the separate billing regulations on issuers, states, Exchanges, and consumers are not unreasonable, are necessary to ensure compliance with Congress' direction in section 1303, and are not "high."

HHS claims that "the separate billing regulation would disproportionately burden communities who already face barriers to accessing care, such as individuals with limited English proficiency (LEP), individuals with disabilities, rural residents, those with inconsistent or no access to the internet, those with low levels of health care system literacy, and individuals within other marginalized communities." In the proposed rule, HHS identifies marginalized communities as including: "Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons."[35] Yet HHS provides no evidence to support the assertion that these communities would be disproportionality burdened. Nothing in the proposed rule justifies the assumption that any burden will fall more heavily on these allegedly marginalized communities. Because HHS had already made clear that enrollees would not lose coverage if they combined payments, the argument that the 2019 regulations pose a "barrier to accessing care" is spurious.

HHS also claims that getting rid of the separate billing regulations would "promote[e] health equity."[36] No explanation is given as to what aspect of health is unequitable or how the

[34] 86 Fed. Reg. 35204.
[35] *Id.* at 35187 n.117.
[36] *Id.* at 35179.

proposed regulations would fix that inequity, making any claims that the proposed rule promotes health equity arbitrary and capricious.

HHS states that allowing separate bills is "one way in which an issuer may satisfy the separate payment requirement" but is not "the only method."[37] But if the separate payment requirement allows, but does not require, there to be separate bills, why is HHS still allowing that method as an option when it allegedly leads to so many unjustified burdens, consumer confusion, and barriers to care, and results in inequity? That HHS will continue to allow separate billing as under the 2019 regulations is devastating to its argument for the proposed rule which relies entirely on how allegedly bad the 2019 Program Integrity Rule is.

2. Consumer Confusion

HHS also "reassessed the value of the separate billing policy and no longer believe it is justified in light of the … high likelihood of consumer confusion and unintended losses of coverage."[38] HHS's assertion that consumers cannot figure out how to pay multiple bills is not supported with any evidence. Policy holders routinely receive multiple bills from their insurance companies or providers, especially for those with plans that have deductibles or cost sharing. For example, policy holders that have Medicare as well as a supplemental Medigap policy must pay a separate premium to the private insurance company that provides the Medigap.[39] Likewise, a policy holder who have both a Medigap policy and a Medicare Prescription Drug Plan may need to make two separate premium payments, even if the two plans come from the same provider.[40] Consumers are presumably not confused enough to be able to pay those separate bills. There is no reason why a separate bill for abortion coverage would be any different. A plan issuer can and should explain at the top of each bill that "there are two separate bills enclosed that must be paid in separate transactions" or state that policy holders "cannot combine payment for this bill with any other payment." Indeed, the separate billing regulations require the issuer to instruct the policy holder to pay the separate bills in separate transactions.[41] Further, when it comes to HHS's proposal to extend the open enrollment period to January 15th, it accepts consumer confusion and loss of coverage as an acceptable cost. The proposed rule acknowledges that the extended deadline "could cause some consumers to miss out on coverage for the month of January altogether."[42] This proposal makes HHS's rationale for replacing the separate billing regulations arbitrary and capricious.

HHS states that under the proposed regulations it "would encourage any issuer electing to send two separate monthly bills to do so in a manner that minimizes consumer confusion and

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[37] *Id.*
[38] *Id.* at 35177.
[39] *What's Medicare Supplement Insurance (Medigap)?*, MEDICARE.GOV, *available at* https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap (last accessed July 28, 2021).
[40] *Medigap & Medicare Drug Coverage (Part D)*, MEDICARE.GOV, *available at* https://www.medicare.gov/supplements-other-insurance/whats-medicare-supplement-insurance-medigap/medigap-medicare-drug-coverage-part-d (last accessed July 28, 2021).
[41] 45 C.F.R. § 156.280(e)(2)(ii)(B).
[42] 86 Fed. Reg. 35168.

promotes continuity of coverage."[43] Yet there is no reason why such efforts could not be done consistent with the existing regulations in the 2019 Program Integrity Rule. Moreover, to the extent that HHS is expanding the Navigator Program, Navigators could assist consumers in understanding the separate billing requirements, eliminating consumer confusion, and minimizing any consumer support burdens on issuers.

HHS states that certain consumers would disproportionally be confused and face logistical obstacles, specifically "individuals with limited English proficiency (LEP), individuals with disabilities, rural residents, those with inconsistent or no access to the internet, those with low levels of health care system literacy, and individuals within other marginalized communities." First, HHS incorrectly assumes that individuals in these communities will want abortion coverage, but many do not. Second, for policy holders in these communities who have zero-dollar premium QHPs, they only have to pay the minimum $1 premium cost for abortion services and will only be receiving a bill requesting payment for that amount. There will be no confusion over separate bills and separate transactions for these policy holders. Third, HHS provides zero evidence that persons that are poor, rural, or with disabilities, and racial, religious, and sexual minorities are capable of paying one bill, but wholly incapable of paying a separate one for abortion. Rather HHS is engaging in negative and discriminatory stereotyping of these communities. Fourth, to the extent that policy holders face certain obstacles to paying a separate bill arriving in the same envelope, those obstacles would likely already be faced by paying a combined bill, resulting in no higher burden. For example, if someone needed internet access to pay a separate bill, they would also already need internet access to pay a combined bill. If someone needed help reading a separate bill, they would also already need help reading a combined bill. If someone needed to travel to town to post a separate payment, they would also already have to travel to town to post a combined payment. In short, if a policy holder can pay a combined bill, they can pay a separate bill.

HHS speculates that "[f]ailure to pay the separate bill entirely due to consumer confusion could also lead to a complete loss of coverage, further exacerbating existing health disparities and jeopardizing health outcomes."[44] But the 2019 Program Integrity Rule addressed that concern in its regulations: "Notwithstanding this instruction, if the policy holder fails to pay each of these amounts in a separate transaction as instructed by the issuer, the issuer may not refuse the payment and initiate a grace period or terminate the policy holder's QHP coverage on this basis."[45] As such, HHS fear that any inadvertent combined payment would lead to loss of coverage is unfounded and arbitrary and capricious. To the extent that a policy holder only pays the cost of the premium excluding Hyde-restricted abortion services and fails to pay the cost of the premium for such abortion services, an issuer can follow up with the policy holder and communicate that an additional payment is due (as it would for any other non-payment). If a policy holder continues to refuse to pay the premium amount for coverage of Hyde-restricted abortion services, an issuer could drop coverage of only such abortion services while maintaining coverage for all other services. HHS's claim that the separate billing regulation would lead to a complete loss of coverage is unfounded and arbitrary and capricious.

[43] *Id.* at 35178.
[44] *Id.* at 35179.
[45] 45 C.F.R. § 156.280(e)(2)(ii)(B).

HHS also speculates that the separate billing regulations might result in issuers withdrawing coverage of [Hyde-restricted] abortion services," transferring these costs to "some enrollees," which "could disproportionately impact low-income women who may already face barriers to accessing quality health care due to their socioeconomic status, gender, sexual orientation, nationality, or race."[46] First, the premise is flawed; abortion is not "health care." Abortion an inhumane practice that ends the life of a separate, unique living human being. Second, because federal funds cannot be used to pay for abortion services by the Hyde Amendment, HHS advocating for greater abortion access to justify the proposed rule flies in the face of long-standing bipartisan public policy. The federal government stands on the side of life: "A core component of the HHS mission is the dedication to serve all Americans from conception to natural death, including those individuals and families who face or who are at high risk of economic and social well-being challenges."[47] Indeed, that the Supreme Court has limited the ability to criminalize abortion "implies no limitation on a State's authority to make a value judgment favoring childbirth over abortion and to implement that judgment by the allocation of public funds. An indigent woman desiring an abortion is not disadvantaged by [a state's] decision to fund childbirth" and not abortion.[48]. By its stated justification, HHS reveals its true intent: hostility to Hyde and any other restriction on greater abortion access—a position you, Secretary Becerra, have admitted to numerous times as Secretary, including in testimony before Congress. Third, whether issuers choose to offer QHPs that include Hyde-restricted abortion services is their choice and whether a policy holder is able or chooses to pay the costs associated with any Hyde-restricted abortion services is up to them. Congress prohibited federal funds from being used for such services, and HHS should do everything in its power to respect the law.

3. Reliance

HHS provides no explanation for why alleged reliance on the methods approved in the 2016 guidance, justifies returning to those policies. To the extent that stakeholders relied on approved methods that are inconsistent with the statutory text, HHS cannot use that as a reason to promulgate regulations that violate Congress' direction. HHS also does not specify how it knows how many entities "relied" upon the 2016 guidance as opposed to the 2019 Program Integrity Rule. HHS's reliance on reliance to support its proposed regulations is arbitrary and capricious.

4. Federal District Courts

HHS must make an independent assessment of and should continue to defend the 2019 Program Integrity Rule in court. Whatever the effect of Washington State's "Single-Invoice Statute," that decision should not impact regulations for the remaining states that do not have such a policy. To the extent that the separate billing requirement was enjoined because of a mid-year implementation date, HHS can remedy that issue by providing sufficient time for issuers to comply and setting an implementation date at the beginning of a new policy year, such as for

[46] 86 Fed. Reg. 35179.
[47] U.S. Dep't Health & Hum. Servs., *Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan*, https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html (last reviewed Jan. 24, 2020).
[48] *Maher v. Roe*, 432 U.S. 464, 474 (1977).

2022 as suggested for the Department's other proposed changes in the NPRM.

If the Maryland district court was correct (and it is not) that the separate billing requirement would violate section 1554 and create an unreasonable barrier to obtaining appropriate medical care and impede timely access to health care services, then for HHS to continue to allow that method as means to satisfy section 1303 would also violate section 1554 and be arbitrary and capricious. But section 1303's separate payment requirement itself cannot be a violation of section 1554 and HHS has yet to propose a method of how issuers can collect separate payments without sending separate bills. Issuing multiple bills or collecting multiple payments is not an unreasonable barrier to obtaining healthcare. Indeed, policy holders already receive multiple bills throughout the year and make monthly payments for their insurance coverage. And assuming a policy holder pays their bills on time, nothing in the separate billing regulations impede their access to "timely" abortion services, which should not be consider "health care services."

D. HHS Ignores the Benefits of Keeping and the Costs of Eliminating the Separate Billing Regulations

HHS does not discuss the benefits of the separate billing regulations or the costs associated with eliminating them. HHS believes "the proposed changes to § 156.280(e)(2)(ii) offer issuers options for meaningful compliance with section 1303 and ensure appropriate segregation of funds, without imposing the operational and administrative burdens of the separate billing regulation and without causing additional consumer confusion and unintended losses of coverage."[49] But ignoring section 1303's separate payment mandate cannot be "meaningful compliance." The first benefit of the separate billing regulations is that it is the only reasonable interpretation of Congress's direction in section 1303. Separate billing is not only necessary for issuers to collect separate payments, but it also helps ensure issuers comply with section 1303's prohibition against using federal funds for Hyde-restricted abortion services. Without separate billing and separate (distinct) payments, it will be more difficult for HHS oversight to hold issuers accountability for their use of taxpayer dollars.

Another benefit of the separate billing regulations is that they increase consumer transparency. Without separate bills, many consumers will likely inadvertently pay for plans that includes coverage for abortion services that violate their consciences or religious beliefs. HHS suggests that consumers would be unable to understand separate payments after receiving separate bills and instructions to make payments in separate transactions yet suggests that QHP information on *HealthCare.gov* would be sufficient notice to consumers that their plan covers abortion. This is absurd. It is much more likely that a consumer would understand they owe multiple payments after receiving multiple bills that direct payments in separate transactions than understanding that they must review pages and pages of plan information to find the one line that mentions the plan covers abortion. Indeed, HHS even issued an FAQ sheet detailing the steps it takes to figure out whether a plan covers Hyde-restricted abortion services.[50] Steps include

[49] 86 Fed. Reg. 35178.

[50] U.S. Ctrs. for Medicare & Medicaid Servs., Frequently Asked Questions for Agents, Brokers, and Assisters Providing Consumers with Details on Plan Coverage of Certain Abortion Services (Nov. 21, 2018),

selecting the correct QHP, clicking "Details," then locating "Other Services," and looking for any reference to abortion. In the proposed rule, HHS fails to consider the increased time burden and confusion for consumers to discover whether their plan includes abortion coverage. If this burden is not unduly confusing (which it is), then neither is consumers having to pay separate bills.

The third method HHS proposes—giving a policy holder an initial notice of the abortion surcharge around the time of enrollment—obfuscates the abortion charge, decreasing consumer transparency. This "notice" may be buried in pages upon pages of plan documents, after which the abortion surcharge would be essentially hidden from consumers within a monthly premium that is paid for in a single (not separate) payment.

HHS utterly fails to consider the burden of consumers who will inadvertently pay for abortion in violation of their consciences or sincerely held religious beliefs and the benefit of the separate billing requirement to give notice to those consumers. Following HHS's reasoning in the proposed rule, this burden will fall disproportionally on marginalized communities.

What HHS treats as a "bug" is a feature. Abortion is a horrible practice that Congress has for decades and everywhere prohibited funding for. The controversy over the issue raged during the passage of the Affordable Care Act and the result was the funding restrictions in section 1303. That you, Secretary Becerra, did not like that particular result does not give you license to ignore the law. The proposed rule is yet another transparent attempt by HHS to cater to Big Abortion by getting rid of regulations that Planned Parenthood opposes because it hurts their image and bottom line.

Consumers must be reminded every month that they are paying for abortion in the most explicit way possible because (1) abortion is not healthcare and extinguishes an innocent human life, (2) the federal government absolutely cannot pay for abortion, (3) people absolutely need to know and be frequently reminded if their plans and those of their minor children cover abortion to avoid egregious violations of conscience. Multiple separate billings are precisely the point and precisely what the law requires.

E. Conflict of Interest

Secretary Becerra, while attorney general of California you led a coalition of states to oppose the 2019 Program Integrity Rule. Any involvement you may have in continuing the same pro-abortion crusade through advocating or pushing the same litigation position at HHS creates a clear conflict of interest. As such, I ask that you recuse yourself from any rule making or litigation with respect to the 2019 Program Integrity Rule or any other regulations or matters you litigated. I also ask that you reuse yourself from any decision-making regarding the separate billing provision or discussion of HHS litigation positions in the three federal appeals on hold pending finalization of the proposed rule.

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https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-on-Providing-Consumers-with-Details-on-Plan-Coverage-of-Certain-Abortion-Services.pdf.

II. Other Provisions

A. Exchange Direct Enrollment Option Repeal

HHS proposes removing the Exchange Direct Enrollment option (DE option) that allows states to eliminate the use of the single, centralized exchange *HealthCare.gov* and replace it with a decentralized enrollment system via private sector entities (such as insurers, web-brokers, and agents and brokers). I oppose the removal of § 155.221(j) and the repeal of the Exchange DE option.

The DE option formalizes a regulatory process for states to adopt a new Exchange model that takes advantage of private-sector websites to deliver a better consumer experience. The DE option for states meets all statutory and regulatory requirements for operating an Exchange and builds on the success of direct enrollment (DE) and enhanced direct enrollment (EDE). According to HHS Centers for Medicare & Medicaid Services (CMS) data, the EDE pathway more than doubled enrollments during the 2021 OEP, increasing from 521,000 to 1,130,000. In addition, EDE has attracted a higher proportion of new consumers and has increased the portion of consumers who made active plan selections. Yet HHS proposes to eliminate this important state flexibility by repealing section 155.221(j), which provides an option for states to use web brokers and issuer websites as the primary consumer shopping experience for QHPs in their states.[51]

As justification for rolling back this state flexibility, CMS cites significant changes to policy and operational priorities resulting from recent shifting policy goals, as well as the enactment of new federal laws, as well as lack of interest from states and potential misalignment with unstated administration priorities. First, some of the wording used by HHS in the preamble discussing this topic has caused significant confusion among stakeholders. CMS should clarify that it does not intend to discontinue the ability for all exchanges, including SBEs, SBE-FPs, and FFEs, to continue to use DE or EDE to enroll qualified individuals into QHPs as current done.

Second, the proposed changes in law and policy rationale cited in the preamble provide ample justification for maintaining or expanding state flexibility rather than rolling it back. States need flexibility from the federal government to address unique issues facing their markets to ensure affordable coverage for their residents. For example, according to CMS, web brokers have shown better ability to enroll new consumers than either Navigators or *HealthCare.gov*.[52] Bringing new enrollees into the market is vital for the sustainability of the risk pool and the ACA marketplaces. The enhanced assistance provided by web brokers and traditional agents and brokers is particularly important in the volatile economic environment due to the COVID pandemic, in which millions of Americans lost their jobs or were forced to change jobs and may have lost their job-based health insurance coverage. Such consumers are often wholly unfamiliar

[51] In addition to proposing to increase the FFE user fee to 2.75% of premium per member, per month for plan year 2022, HHS is also proposing to increase the user fee for states pursing the DE option on the FFE. I urge HHS to retain both the DE option and the lower user fee rate to incentivize states to pursue these flexibilities.

[52] *See* U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., AGENTS AND BROKERS IN THE MARKETPLACE, *available at* https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Agents-and-Brokers-in-the-Marketplace.pdf (last accessed July 28, 2021).

with the individual health insurance market, including available plans, provider networks in their area, and cost-sharing structures. Licensed state agents and brokers and web brokers provide more in-depth information of available coverage options and are better positioned to reach consumers losing employer-sponsored coverage than Navigators, which are responsible for less than 1% of QHP enrollments each year.

As previously acknowledged by HHS, government-run exchanges and Navigators have tended to "crowd out" issuer, web broker, and agent and broker outreach and marketing efforts.[53] States need more flexibility, such as the DE option, offering the ability to build on the proven success of DE and EDE to improve the consumer experience and create more competition and choice in the market. States implementing the DE option will provide stronger incentives for the private sector to participate in the market by removing or lessening the impact of dominant public sector competitors and making these private sector participants the primary enrollment channel. Consequently, the DE option creates more competition among DE entities to improve the consumer experience. In addition, it will better connect consumers with a licensed agent or broker who has more expertise and experience assisting consumers. In fact, consistent with E.O. 13985, the DE option "holds potential to better connect vulnerable populations to coverage than a centralized one-size-fits-all Exchange model."

Recent changes to HHS's policy and operational priorities do not justify the wholesale repeal of the DE option. For example, every DE and EDE partner has already implemented the changes needed to update the increased Premium Tax Credit (PTC) levels for qualified individuals in every income bracket under American Rescue Plan (ARP). In fact, unlike many SBEs, DE and EDE partners have implemented the changes required by ARP in a cost-effective manner and without the need to apply for or use federal dollars. Of course, every new administration will bring in a new set of priorities and redirect resources to those priorities. And in light of the substantial work necessary to implement the ARP, it is entirely understandable to focus resources on that important work right now. But it is arbitrary and capricious to use ARP as a pretense for the wholesale repeal of the DE option. To justify repealing the DE option, the proposed rule relies largely on the need "[t]o foreclose the possibility that federal funding and resources will be diverted from efforts to provide direct benefits to consumers made available under recent legislation to optional programs." Yet this need is temporary while the proposed change is indefinite. The existing concerns over COVID are insufficient to support permanently changing regulations. The ARP provisions expire at the end of 2022, at which point HHS will be able to transition back to normal operations. States will need additional options to address the "cliff" created by this transition, thus CMS should make every effort to maintain and expand state flexibility rather than roll it back. However, if HHS decides to focus its resources on these other priorities, I suggest that the Department delay the effective date of the DE option to coincide with the expiration of the ARP provisions rather than remove it entirely.

HHS claims that permitting the Exchange DE option would detract from its efforts to review existing policies and regulations in line with E.O. 14009 and 1398, and recent legislation. Yet, HHS does not explain how allowing state Exchange DE option would undermine its ability to review policies and regulations and comply with legislation, making this rationale arbitrary and capricious. In fact, aside from the need to focus resources on implementing ARP, the DE

[53] 86 Fed. Reg. 6138, 6142 (Jan. 19, 2021).

option aligns quite well with the E.O. 13985 and both sections 1 and 3 of E.O. 14009. Consistent with E.O. 13985, the DE option "holds potential to better connect vulnerable populations to coverage than a centralized one-size-fits-all Exchange model." Consistent with sections 1 and 3 of E.O. 14009, EDE has proven to be possibly the most effective policy to protect and strengthen the ACA. Time and again, prior implementation decisions by CMS tended to erode the ACA-regulated insurance markets, leading to unnecessary barriers to health insurance. EDE brought the private sector back and re-introduced powerful competitive dynamics vital to making markets flourish by bringing in more new people and more active purchasers. Making EDE the primary enrollment platform would only serve to strengthen the ACA-regulated markets and, importantly, would better connect the millions of people who are eligible for subsidies under the ACA but remain uninsured. Repealing the DE option forecloses the opportunity for states to come forward with an Exchange model that would strengthen the ACA-regulated markets. There is no cost related to maintaining the DE option aside from the resources necessary to review a state proposal. HHS is making the determination that the resources necessary to review a state proposal outweigh the possibility a proposal could deliver better results than the status quo. Thus, by repealing the DE option, HHS is prejudging every possible state proposal without ever seeing it. This is arbitrary and capricious.

In addition, HHS states in the preamble "that shifting away from *HealthCare.gov* or State Exchange websites as the primary pathway to enroll in and receive information about coverage would harm consumers by unnecessarily fracturing enrollment processes among the Exchange and possibly multiple direct enrollment entities operating in a state."[54] This alleged concern is clearly unfounded, as both DE and EDE entities already exist within the *HealthCare.gov* ecosystem today, and have successfully processed millions of consumer enrollments with the Exchanges. The proposed rule offers no justification for HHS's reasoning that the implementation of the Exchange DE Option in either a State-based Exchange (SBE) DE or SBE on the federal platform (SBE-FP) DE would change that. Furthermore, whenever a state moves from the federally-facilitated exchanges (FFE) to establish its own SBE as envisioned by the ACA, there is a risk that consumers will get lost in the migration and lose their coverage. However, HHS has successfully collaborated with new SBEs in several states to move millions of enrollees from the FFE to SBEs, providing a seamless transition for those consumers and helping them get covered while minimizing coverage interruptions.

Furthermore, HHS states that under the DE option, consumers could be directed to consumer enrollment entities that "only offer assistance with a limited selection or products and some of those products may not provide, for example, MEC for consumers."[55] Again, this alleged concern is without any basis. Not only that, but HHS appears to completely ignore its own, robust suite of consumer protections applicable to DE and EDE entities today. Federal regulations currently on the books require that all DE and EDE entities operating in FFE states provide consumers with the ability to view all QHPs offered through the Exchange,[56] and DE/EDE entities cannot display QHP recommendations based on compensation received from QHP issuers.[57] Furthermore, under the Exchange DE Option for SBEs, the SBE DE must ensure

[54] 86 Fed. Reg. 35167.
[55] *Id.*
[56] *See* 45 C.F.R. § 155.220(c)(3)(i)(B).
[57] *See Id.* § 155.220(c)(3)(i)(L).

at least one approved web-broker, EDE partner or other approved DE entity meets requirements that align with the FFE standards under the regulations,[58] ensuring that consumers have at least one option through which to view and access enrollment to all available QHPs in the state. Additional consumer protection standards already applicable to DE and EDE entities include:

- If they offer non-QHPs (including plans that may not provide Minimum Essential Coverage), DE/EDE entities must clearly distinguish between QHPs and non-QHPs[59] and must display and market non-QHPs on separate website pages from QHPs[60];
- DE/EDE entities must provide consumers with correct information without omission of any material facts on their products, and must not engage in misleading/coercive/discriminatory conduct[61]; and
- DE/EDE entities must limit marketing of non-QHPs during the Exchange eligibility and QHP selection process to minimize consumer confusion.[62]

These requirements are in addition to any state requirements applicable to licensed agents and brokers.

The preamble also cites concern that state flexibility in this area could somehow disrupt coordination of coverage with Medicaid and Children's Health Insurance Program (CHIP), or otherwise create a barrier to consumers seeking Medicaid and ACA coverage. But once again, these concerns fly in the face of HHS's own regulations and have no basis in fact. The eligibility applications EDE entities are required to implement are designed to provide the Exchange with the information necessary to evaluate eligibility to enroll in QHPs, as well as to evaluate eligibility for the advanced premium tax credit (APTC), cost-sharing reductions (CSRs), Medicaid, and CHIP. Consumers who complete an eligibility application on an EDE entity's website are provided with an eligibility determination notice (EDN) from the Exchange, and related information must display within the EDE entity's website about consumers' eligibility. Therefore, if a consumer is determined eligible for Medicaid or CHIP after completing an EDE application, they will receive the same information in their EDN about that eligibility and next steps in precisely the same manner as if they completed the application on *HealthCare.gov*. The assertion that there are "potential negative downstream impacts"[63] of the DE option that could "disparately impact[] certain vulnerable groups" is attenuated at best.[64]

Finally, HHS claims that there is a "general lack of interest expressed by states in the option."[65] However, this is yet another unreasonable justification, as it has only been a matter of months since the DE Option was finalized on January 19, 2021, the DE option is not available until plan year 2022, and HHS's current proposal to repeal the flexibility would make states hesitant to apply. Moreover, just as HHS and other federal agencies are facing unprecedented

[58] *Id.* § 155.220(c)(3)(i)(A), (D).
[59] *Id.* § 156.1230(a)(1)(iii).
[60] *Id.* § 155.221(b)(1).
[61] *Id.* §§ 156.1230(b)(2); 155.220(j)(2)(i).
[62] *Id.* § 155.221(b)(3).
[63] 86 Fed. Reg. 35206.
[64] *Id.* at 35167.
[65] *Id.* at 35166.

challenges related to addressing the COVID pandemic and implementing numerous new federal requirements, states are also working diligently to address their citizens' needs in highly challenging circumstances to ensure that our nation can emerge from the pandemic strong and healthy. States desire to do what is best for their residents and their health and should not be penalized by preemptively rolling back flexibility and authority over their healthcare systems. HHS assumption that states are not interested is premature. I urge HHS not to repeal the DE option, and leave the DE option in place for at least a year to give states an opportunity to explore the options more fully and express interest.

B. Open Enrollment Period Extension

HHS proposes to extend the Annual Open Enrollment Period (OEP) by one month from 45 days to 75 days. Specifically, the current enrollment period from November 1 to December 15 would be extended to January 15 for plan years 2022 and beyond. This extension is unnecessary. HHS fails to provide evidence that 45 days is insufficient and an additional 30 days I warranted. If finalized, this would mark the fourth time HHS has changed the dates for the OEP since launching the Exchanges in the fall of 2013.

HHS has presented no evidence in the proposed rule that more time to enroll will actually help consumers. It is commonly known that whatever the length of the OEP, most people wait until the last minute to enroll. Therefore, extending the deadline does not provide any clear informational benefit. Expanded use of EDE is encouraging more people to actively review their plan. Assisters and brokers and agents will always have issues due to people waiting until the last minute. Changing the deadline does not solve this problem.

HHS also provides no support for its assertion that additional time is needed or would be used by consumers in underserved communities. If consumers are unable to obtain the assistance they need in 45 days, HHS provides no evidence that 30 more days would change that. Moreover, it makes more sense to have the enrollment period end before the holidays when many people take time off work at the end of December and beginning of January. HHS's proposed deadline will also complicate operational processes for both issuers and the Exchanges, leading to increased costs and potentially degrading the consumer experience.

There are several strong reasons why maintaining the current OEP would benefit consumers and strengthen the market, as HHS has acknowledged in prior rulemaking. First, consumers need consistency in deadlines from year to year to ensure that they can shop for and enroll in a plan before the deadline. As HHS has said prior rulemaking, the current deadline encourages consumers to maintain continuous coverage and helps to ensure that they receive a full year of coverage.

Second, having deadline for different types of plans would cause consumer confusion. Extending the OEP past December 15 will create unnecessary consumer confusion, since it would create two deadlines for consumers shopping during OEP: one deadline (December 15) for selecting a plan that will have an effective date of January 1, and another, second deadline (January 15) marking the end of the OEP. Confusion around the two deadlines could lead to

consumers experiencing a gap in their coverage if they wait until after December 15 to enroll in a plan for the upcoming year.

Not only will this change cause consumer confusion, but it will also lead to adverse selection and increased premiums for consumers, both of which violate HHS's purported policy goals. HHS acknowledges the adverse selection issue without discussion in the proposed rule, but the risk of adverse selection warrants much more thorough consideration. For example, some individuals may choose to let their coverage lapse by waiting to select a plan until January 15, creating a gap in coverage of two months (January 1 through March 1). This creates a significant adverse selection risk and issuers will likely raise their premiums to account for this risk. Others may let their plan auto-reenroll, but then change their mind after January 1, but before January 15. This creates administrative confusion, including over plan coverage and payments, and increased costs.

Any negative impacts of the current December 15 deadline are minimal and can be easily mitigated. Large, unexpected premium increases from year to year are not common, nor do they present a substantial burden to consumers when they occur. Individuals already receive notice of changes in premiums and APTC amounts in October of each year. Rather than extending the OEP deadline, HHS should work to improve the information provided in the notice to ensure it accurately and clearly communicates plan changes for the upcoming year. A better option is to implement policies to encourage people to sign up for coverage in November and not wait until the last minute. HHS does not need a new SEP for people automatically re-enrolled who experience a significant cost increase. To the extent this is an issue, enhanced consumer engagement is the answer. As discussed above, enhanced noticing would be very helpful, as would be enhanced training for Navigators and agents and brokers who can help consumers understand that premiums change each year, navigate other plan options, and sign up in a timely manner.

On balance, the positive impacts of maintaining the current six-week OEP far outweigh any negative impacts outlined by HHS. HHS should reject the OEP extension proposal and instead should keep the current OEP dates of November 1 to December 15, which have been in place for four consecutive years.

I also oppose the proposal to not require pre-enrollment verification. This opens the door for abuse, fraud, and inadvertent enrollment for individuals who do not actually qualify. HHS does not discuss how coverage will be assessed if a consumer is determined post-enrollment to not have a qualifying household income.

C. Navigators Program Expansion

HHS proposes to expand the Navigator program, which provides grants to community partners to help individuals "navigate" their insurance options under the ACA. Specifically, HHS proposes increased funding and expanding the program to require certain post-enrollment assistance.

Increased funding. I oppose the increased funding for the Navigator program. HHS provided no evidence that there is a need for more Navigators or that the program has been effective, especially relative to the cost. Indeed, according to publicly available CMS data, Federal Navigator grantees are responsible for less than 1% of QHP plan selections each year.[66] In addition, CMS data show that the average annual cost for enrolling individuals through Navigators is significantly higher than enrolling people through licensed health insurance agents and brokers.[67] Other research has verified that Navigators are ineffective in carrying out their core statutory mission of facilitating enrollment in QHPs. For example, a 2019 *Health Affairs* article found that "[state-licensed health insurance agents and brokers] represented the most common source of help both on and off Marketplace… Only 5 percent of on-Marketplace respondents received help from customer service representatives or navigators."[68] Another study examining two SBE's found that, while 34% of respondents used a broker, "[v]very few talked to assisters in the community." The Navigator program is also a way to funnel taxpayer dollars to Big Abortion. For example, in 2013 Planned Parenthood received around $655,000 under the Navigator program.[69] Rather than continuing to pour tens of millions of dollars into this wasteful, ineffective program—and increasing premiums for consumers through increases in user fees to do so—HHS should invest in improving proven, cost-effective pathways for enrolling people like licensed agents and brokers, web brokers, direct enrollment, and enhanced direct enrollment.

Additional requirements. HHS also proposes reinstating the requirement that Navigators in the FFE provide post-enrollment assistance beyond applying for and enrolling in coverage, including with the process of filing Exchange eligibility appeals and PTC reconciliation. I oppose making the topics in § 155.210(e)(9) requirements rather than permissible actions a Navigator can take.

Requiring Navigators to provide information and assistance on post-enrollment topics goes beyond the requirements of the statute and could limit Navigators' flexibility to design their program in a way that best meets their community needs, consumer demands, and organizational resources and expertise. As the proposed rule notes, the only post-enrollment assistance required by the statute is to provide referrals to consumers with a grievance, complaint, or question regarding coverage or a coverage determination.[70]

By directing Navigators to provide assistance beyond a referral, the requirement could put enrollees at risk of receiving poor information from a Navigator who has no professional expertise or capacity to properly address the issue. For example, Navigators would be required to help consumers with the process of filing appeals of exchange eligibility determinations,

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[66] See Centers for Medicare & Medicaid Services, 2016-2020 Navigator Funding and Enrollment Data available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Navigators (last accessed July 28, 2021).
[67] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., AGENTS AND BROKERS IN THE MARKETPLACE 8, *available at* https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Agents-and-Brokers-in-the-Marketplace.pdf (last accessed July 28, 2021).
[68] Joachim Hero, et al., *Decision-Making Experiences of Consumers Choosing Individual-Market Health Insurance Plans*, HEALTH AFFAIRS (Mar. 2019).
[69] Elise Viebeck, *Planned Parenthood to Get ObamaCare "Navigator" Funds*, THE HILL (Aug. 15, 2013, 4:44 PM), https://thehill.com/policy/healthcare/317249-obamacare-navigators-include-planned-parenthood-affiliates.
[70] 86 Fed. Reg. 35163.

requiring Navigators to understand the appeal process and make accurate representations to consumers and putting consumers at risk of receiving inaccurate or incomplete information about the appeal process. This requirement is inconsistent with the requirement to distribute fair and impartial information. Consumers should be informed that the Navigator is not their advocate, cannot be partial, and does represent their interests.

Further, while regulations expressly restrict Navigators from providing tax assistance or advice, a requirement on Navigators to provide information on taxes would substantially increase the risk that a Navigator violate this restriction and provide incomplete or inaccurate information on these complex topics, causing significant consumer harm. HHs proposes no safeguards to ensure that Navigators correctly understand the information available on *irs.gov*, such as form instructions and tax credits, further putting consumers at risk of harm. Navigators who are not tax experts should only be required to direct consumers to the IRS website and to a tax professional for further assistance.

Requiring Navigators to assist with the topics could lead to inadvertent misrepresentations and harm of consumers, while *allowing* such assistance allows Navigators to help in ways that are consistent with their expertise and comfort level. However, to the extent that the Department chooses to adopt such requirements, I suggest that Navigators also be required to disclose that they are not legal or tax experts nor providing legal or tax advice to consumers.

The proposed rule does not discuss the practical implications of the proposed Navigator requirements. what happens when a Navigator incorrectly assists a consumer with filling out forms? Will the consumer be considered at fault, or will the Navigator bear some responsibility? How should a Navigator respond when a consumer does not want information on a topic required by the regulations? Are Navigators required to *offer* such information and assistance or are they required to *give* each consumer such information and assistance? If HHS adopts the proposed requirements, it should address these and other practical considerations.

The proposed rule also does not discuss how these additional duties will burden Navigators who do not have the correct expertise or the time and resources to learn. The proposed rule also does not take into consideration how these additional requirements will impact the existing and potential pool of Navigators. At a minimum, if the requirements are adopted, Navigators should not be required to perform the additional duties mid-grant. Only new grantees should be required to perform the duties. Adding such requirement midway through the 36-month period of performance places an unnecessary burden on Navigators to modify their programs to meet the requirement. Current grantees did not accept the grant with the condition of such requirements and to change it mid-grant will negatively impact Navigators who are not in a position or unwilling to perform all the newly required duties.

In line with E.O. 13985, I suggest that Navigators be required to inform consumers about the availability of any plans that exclude coverage for Hyde-restricted abortions as individuals in marginalized communities should also be able to opt out of insurance plans that coverage Hyde-restricted abortions. I also suggest that Navigators help eliminate any potential consumer confusion regarding the separate billing requirement by assisting consumers in understanding

that they need to make separate (i.e., distinct) payments for any Hyde-restricted abortion coverage included in their QHP.

D. New Monthly Special Enrollment Period for Certain Low-Income Consumers

HHS proposes to create a new, monthly special enrollment period (SEP) for qualified individuals or enrollees, or the dependents of a qualified individual or enrollee, who are eligible for APTC, and whose household income is expected to be no greater than 150 percent of the FPL. I oppose the adoption of the proposed monthly SEP because it violates the text of the ACA, is completely unnecessary, and would increase adverse selection.

Contrary to ACA. The ACA allows insurance companies in the individual market to restrict enrollment to open enrollment or special enrollment periods. Insurers are required, at a minimum, to establish the special enrollment periods for qualifying life events that apply to group health plans. Regarding the Exchange, the ACA also requires HHS to establish an initial open enrollment, an annual open enrollment period, the same special enrollment periods that apply to group health plans under the IRS Code, other special enrollment periods similar to circumstances for periods identified for Medicare Part D enrollment, and special monthly enrollment periods for American Indians/Alaskan Natives. According to the interpretative canon, *expressio unius est exclusion alterius*, the inclusion of one is the exclusion of the other. Based on the prescriptive nature of how the statute specifies a list of required enrollment periods for Exchanges, the statute limits HHS's ability to allow additional enrollment periods that are not included in the list.

The ACA also includes a number of provisions that impose a list of requirements on the Secretary, which then give the Secretary discretion to add to the list. However, the list of enrollment periods does not include this discretion. To the extent discretion is allowed it is based on the Secretary's discretion to define an SEP already itemized in the list, such as the meaning of "exceptional circumstance." The proposed monthly SEP does not fit within any SEP permitted in the ACA, and, therefore, HHS's proposal to require a new monthly SEP is contrary to the text of the statute.

Unnecessary. A new monthly SEP is completely unnecessary. Qualified individuals with incomes no greater than 150 percent FPL already qualify for the COVID SEP and can immediately take advantage of zero-premium plans without the SEP until August 15. Thus, people at this income level will have had 6 months since ARP became law to become informed and sign up for zero-premium plans. After the current SEP ends, people newly eligible for premium subsidies will have access to an SEP. HHS argues, even with ARP's provision, some consumers will continue to forgo coverage. But this is true for any benefit. By this logic, there should be no rules on enrollment around any government benefit, as there will always be a portion of people who lack awareness of the rules.

Adverse election. Creating this new SEP is inconsistent with E.O. 14009 because it would weaken the ACA's individual market. This is in part because, as HHS acknowledges in the preamble, the SEP would increase adverse selection. The agency estimates this adverse selection would increase premiums for consumers by 0.5 to 2.0 percent. Like other SEPs, "there is no

limitation on how often individuals who are eligible for this special enrollment period can obtain or utilize it." Adverse selection has been a serious problem under the ACA's guaranteed availability requirements. Enrollment periods are one of the few tools to mitigate this negative impact of the ACA, and rules to tighten enrollment periods have proven successful. Considering there is no clear need or advantage to this SEP, there is no reasonable justification to revert to looser SEP requirements.

E. Increased User Fees for 2022

HHS proposes to increase the user fees for federally-facilitated exchanges and state-based exchanges that use the federal platform for the 2022 plan year. The proposed rule projects these higher fees will result in an increase of about $200 million in fees collected for 2022.

The proposed rule acknowledges that this could increase premium costs for consumers.[71] I agree this is the most likely outcome. Under the current regulations, HHS reduced the Exchange user fee rate from 3.5 percent to 3.0 percent for the 2020 and 2021 benefit years, and then reduced the fee to 2.25 percent for the 2022 benefit year. Because insurers are required to adjust the premium index rate based on the Exchange user fee, these reductions in the Exchange user fee translated to 1.25 percent premium reduction—a one-to-one decrease in premiums for consumers. Any increase in the Exchange user fee rate will likewise increase premiums, and therefore, the proposal to increase the Exchange user fee to 2.75 percent would increase premiums by 0.5 percent for plan year 2022. This is in addition to the new SEPs the rule proposes which HHS estimates will increase premiums by 0.5 to 2 percent.

Not only will the increased fees just be passed on to consumers, but it will also undermine the administration's attempts to make healthcare coverage more affordable and accessible. Regulations, such as the one proposed, that reduce competition and increase premiums for consumers without demonstrable benefit erect unnecessary barriers to accessing health coverage and are inconsistent with E.O. 14009 and section 1554 of the ACA prohibition against regulations that create "any unreasonable barriers" to obtaining "appropriate medical care."[72] Policies that decrease the sustainability and affordability of the market by, for example, increasing adverse selection also erect unnecessary barriers to accessing health coverage. The impact of reduced competition and choice in the market will be most felt by underserved communities which is contrary to the goals of E.O. 14009.

Elsewhere in the proposed rule, HHS justifies not requiring separate billing for abortion services (which is necessary to comply with section 1303's separate payment requirement) because the costs of compliance may be passed on to consumers. This inconsistent reasoning makes HHS's proposal arbitrary and capricious.

For these reasons, I oppose the increase in user fees. To the extent that the increased fees are being used to pay for an expansion of the Navigator program, I oppose an expanded Navigator program (as discussed above) and increased fees used to pay for such an expansion.

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[71] 86 Fed. Reg. 35204.
[72] 42 U.S.C. § 18114.

F. Section 1332 Waivers Reinterpretation

HHS propose reinterpreting section 1332 of the ACA, which allows states (with federal approval) to waive certain ACA requirements if certain statutory procedural and substantive "guardrails" are met. The proposed interpretation would move away from Trump-era guidance and interpretations and largely return to Obama-era guidance and interpretations that make it much more difficult for states to qualify for a waiver. I oppose the proposed changes.

Limits states' flexibility. The proposed rule would significantly curtail states' ability to develop innovative Section 1332 waivers, essentially limiting states to developing waivers that mirror the ACA. It does this by forcing a state waiver to ensure individuals "are enrolled" in the exact same coverage that is already required by the ACA. In contrast, federal regulations require a state waiver to ensure individuals have "access" to the same coverage that is available under the ACA. This current access standard gives states meaningful flexibility to expand the types of coverage options a state waiver can provide. Instead, the proposed rule would undermine Congress's purpose in the statute to give states a meaningful level of flexibility to develop and implement innovative new state health programs. The 1332 waiver represents Congress's recognition that states have always played the primary role in regulating insurance and administering public health care programs.

A number of provisions in the ACA demonstrate Congress's general intent to maintain states' primary role and to provide broad discretion to waive ACA requirements in order to pursue innovative state-based solutions. For example, section 1332(a)(1) provides states with the ability to apply for a waiver of "all or any requirements" specified in paragraph (a)(2), which includes entire parts of subtitle D relating to QHPs, Essential Health Benefits, Exchanges, reinsurance and risk adjustment; cost-sharing reductions under Section 1402; and premium tax credits under 36B. In section 1332(a)(3) on pass-through funding, Congress included powerful language on state plans, allowing them to disqualify individuals and small employers from PTCs, CSRs, and small business tax credits for which they would otherwise be eligible. Since 2017, HHS has approved a number of reinsurance waivers under Section 1332 that have the effect of lowering premiums for unsubsidized individual market plans, including non-QHPs that may not contain the precise consumer protections to the same extent as QHPs (e.g., requirements around verification of Special Enrollment Periods and grace periods). Yet clearly reinsurance programs have tremendous benefit and have expanded coverage options to people who previously could not afford them.

Rather than rolling back flexibility for states to innovate and to develop waivers meeting the particular needs of state residents, HHS should retain the current flexibility provided in regulation and should work closely with states to implement existing and future Section 1332 State Relief and Empowerment Waivers.

Affordability and comprehensiveness. Congress clearly did not intend to establish statutory guardrails that require people to enroll in plans that meet the exact same affordability and comprehensiveness requirements as the ACA. As drafted, the proposed regulations basically only allow a waiver from the requirements of the ACA so long as the waiver meets the requirements of the ACA. For example, section 1332 clearly allows states to waive the Essential

Health Benefits required by the ACA under section 1302(b) of the ACA. Yet, the proposed regulations would require a state waiver plan to ensure people enrolled in plans that meets the requirements of 1302(b). This is nonsensical.

Consumer choice and plan competition. HHS is correct that the goal of the 2018 guidance was to increase consumer choice and competition among private health plans, which should be the goal of the ACA. A robust market that offers plans at different price points and benefit levels is essential to fostering and maintaining a viable, sustainable individual health insurance market. However, the proposed rule selectively relies on public comment letters submitted on prior rules to come to the perverse conclusion that state flexibility, choice, and competition are harmful rather than helpful for consumers. I urge HHS to recognize that policies that have the effect of reducing competition, increasing premiums, or limit consumer choice constitute erecting unnecessary barriers to accessing health coverage and should be considered inconsistent with E.O. 14009. The impact of reduced competition and choice in the market will be most felt by underserved communities, contrary to both the spirit and intent of E.O. 14009.

Systemic barriers and equity. Relying on E.O. 13985, HHS implies that the current guardrails for section 1332 waivers perpetuate systemic barriers. HHS assumes that people of color and underserved groups would be disproportionately impacted but provides no evidence to support such an assertion. However, HHS provides no evidence for such serious allegations. The proposed rule states that the proposed changes to section 1332 waivers would "ensure that systemic barriers to opportunities and benefits for people of color and other underserved groups are not perpetuated."[73] But again, HHS fails to explain what systemic barriers exist and how the proposed changes will eliminate those barriers. HHS's broad claims about systemic barriers are not supported by evidence. Mere speculation that existing regulations may cause a disparate impact on certain groups is insufficient to form a reasoned basis for the proposed changes.

HHS seeks comment on "whether there are policies that meet the statutory guardrails of section 1332 waivers that the Departments could consider that would encourage states to find innovative ways to use section 1332 waivers to focus on equity and expand access to comprehensive coverage for their residents."[74] HHS states that it will "encourage states to include in their analysis whether the proposed section 1332 waiver would increase health equity in line with E.O. 13985."[75] "Health equity" is not defined in NPRM. But E.O. 13985 defines "equity" to mean:

> the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

[73] 86 Fed. Reg. 35181.
[74] *Id.* at 35185.
[75] *Id.* at 35190

To the extend HHS is attempting to promote equity (equal outcomes or prioritizing certain groups), all such efforts must be done in compliance with Title VI and cannot discriminate based on race, color, or national origin. Section 1557 of the Patient Protection and Affordable Care Act guarantees that no individual can "be excluded from participation in, denied benefits of, or be subject to discrimination under" any federally administered or funded health program or activity because of race, color, and national origin as prohibited under Title VI of the Civil Rights Act of 1964.[76] HHS's website further explains:

> Programs that receive Federal funds cannot distinguish among individuals on the basis of race, color or national origin, either directly or indirectly, in the types, quantity, quality or timeliness of program services, aids or benefits that they provide or the manner in which they provide them. This prohibition applies to intentional discrimination as well as to procedures, criteria or methods of administration that appear neutral but have a discriminatory effect on individuals because of their race, color, or national origin.[77]

In its efforts to promote equity, HHS has a legal duty to prohibit discrimination based on race, color, and national origin.

Emergent situations. In §§ 155.1318 and 155.1320(c)(2), HHS proposes changing "public health emergency" to "emergent situation." HHS should reject this proposal. Public health emergencies are situations defined by statute, while HHS explains a situation is considered "emergent" if it is "both unforeseen and urgent." The definition of "emergent situations" is vague, overbroad, and underinclusive. For instance, many natural disasters or pandemics could be "foreseen" but unavoidable. Moreover, there is no limiting principle, like public health emergency defined by statute, that would stop the federal government from considering non-emergency situations "emergent." Deviation and modifications of rules should only occur in limited circumstances.

*Monitoring and compliance***.** I support the deletions in § 155.1320 and § 155.1328 that states must comply with interpretive policy statements, guidance. Policy documents that do not have the force of law should not be required for states to follow.

III. 30-Day Public Comment Period

HHS has provided only a brief, 30-day public comment period for this rule, which proposes to make extensive, substantive policy changes for the fast-approaching 2022 plan year and future plan years. The brief comment period (including over the Fourth of July holiday weekend) does not provide sufficient time for the public to fully consider and comment on the proposed changes, especially in light of the very recent publication of Parts I and II of the 2022 Notice of Benefit and Payment Parameters, the latter of which was published on April 30, 2021, less than two months prior to issuance of this proposed rule. Stakeholders and the public have

[76] 42 U.S.C. § 18116 (incorporating Title VI (42 U.S.C. § 2000d et seq.)).
[77] U.S. Dep't Health & Hum. Servs., *Civil Rights Requirements- A. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. ("Title VI")*, https://www.hhs.gov/civil-rights/for- individuals/special-topics/needy-families/civil-rights-requirements/index.html (last reviewed July 26, 2013).

had insufficient time to digest all these multiple changes and their effects to be able to meaningfully comment on the proposed changes in this proposed rule. Moreover, many stakeholders including health insurance issuers, states, patients, health care providers, and others are still dealing with issues related to the COVID pandemic, which may prevent them from adequately considering and commenting on the proposed rule in the short 30-day comment period provided.

Releasing a proposed rule so late in plan year 2021 that proposes to be in place by plan year 2022 that would impact that year (and plan years moving forward) leads to the impression that HHS is rushing the regulations through because it has prejudged these significant issues and does not intend to fully take public comments in account or make changes in the final rule in response to public comments.

In light of these exigencies and the important, far-reaching changes under consideration in the proposed rule, I urge HHS to extend the comment period by an additional 60 days in order to provide the public and stakeholders with an opportunity to meaningfully comment on the Department's proposals. If HHS instead chooses to continue rushing the proposed rule through the public comment process, I suggest that the applicable changes do not go into effect until plan year 2023, which would give stakeholders, especially health care issuers and states that are dealing with the ongoing impacts of COVID, time to review the regulations and make the necessary changes.

IV. Conclusion

In sum, I urge HHS to withdraw proposed rule and retain the current regulations.

Sincerely,

Rachel N. Morrison, Esq.
Policy Analyst | HHS Accountability Project
Ethics & Public Policy Center