



December 30, 2020

Submitted via the Federal eRulemaking Portal

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9914-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: RIN 0938-AU18 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations

We are writing on behalf of the HIV Health Care Access Working Group (HHCAWG) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV and hepatitis C-related healthcare and support services. We appreciate the opportunity to provide comments on the Proposed Notice of Benefit and Payment Parameters for 2022 (the Proposed Rule).

Standards and protections governing the ACA-compliant individual market must ensure access to comprehensive and affordable coverage for people living with HIV, HCV, and other chronic conditions. Consistent access to affordable, comprehensive health coverage is essential to fulfilling all four key strategies under the Administration's *Ending the HIV Epidemic* initiative: diagnose, treat, prevent, and respond. Access to HIV care and treatment ensures that people living with HIV achieve and maintain viral suppression, which prevents further transmission of HIV because individuals who are virally suppressed have effectively no risk of transmitting HIV to others.¹ To provide meaningful access to care for people living with HIV and others living with chronic conditions, we urge HHS to consider the recommendations and comments detailed below.

¹ See, e.g., *Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV*, NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 2018), <https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.Pdf>.

Exchange Direct Enrollment Options §155.205, §155.220, §155.221

HHCAWG strongly opposes allowing states to transition away from a single, centralized exchange with impartial information to private brokers and agents. This proposal would not only significantly reduce access to HIV prevention services such as testing, pre-exposure prophylaxis (PrEP), and behavioral and substance use services, but also to HIV care and treatment that is essential to preventing HIV transmission.

The ACA has enabled tens of thousands of people living with HIV to transition to expanded Medicaid and private insurance through Marketplaces. The vast majority of enrollees continue to use HealthCare.gov or their state's marketplace to sign up for coverage despite the option to use a private broker or insurer website for years now. Allowing a state to remove this centralized exchange will undoubtedly increase confusion about where and how to access good-quality health coverage, hindering enrollment and prompting many people to give up and become uninsured. Contrary to the Proposed Rule's goal of expanded choices and facilitating a better consumer experience, this would allow states to rob consumers of their only option for a guaranteed, central source of unbiased information on the comprehensive coverage available to them.

Moreover, private brokers and insurers who operate through HealthCare.gov have a track record of failing to alert consumers of Medicaid eligibility and picking and choosing the plans they offer, often based on the size of plan commissions.² As the Proposed Rule notes, the exchanges are currently required to connect eligible individuals to Medicaid and CHIP, reducing and managing churn between private and public programs. While the Proposed Rule maintains the requirement that the exchange continue to be responsible for conducting eligibility assessments for Medicaid, there is no reciprocal obligation that direct enrollment entities inform consumers of their potential Medicaid eligibility. Thus, many individuals that would otherwise have used the single streamlined application offered by the exchange could now be directed to an agent or broker that steers them away from Medicaid eligibility. At a minimum, direct enrollment entities should be required to utilize the exchange to determine if an individual qualifies for Medicaid and refer them to the state Medicaid agency for enrollment as required by Section 1311(d)(4)(F) of the ACA.

Regardless of the action HHS takes here, as the role of agents and brokers increases we urge HHS to ensure that appropriate training is provided so that these entities are prepared to work

² Tara Straw, “*Direct Enrollment*” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, CTR. ON BUDGET & POLICY PRIORITIES (Mar. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

with diverse and low-income populations. To ensure that the specific needs of people living with HIV were met, HHS has in the past coordinated with the HRSA HIV/AIDS Bureau to provide training and resources for Navigators and Certified Application Counselors focused on enrollment considerations for Ryan White HIV/AIDS Program clients. We urge HHS to make these resources and training materials available to agents and brokers as well.

State Innovation Waivers - 31 CFR Part 33 and 45 CFR Part 155

As we previously stated, HHCAWG opposes weakening the guardrails and protections for vulnerable populations in states seeking 1332 waivers and urges HHS to withdraw this proposal. The Proposed Rule seeks to incorporate and codify the substantive waiver approval guardrails that were already weakened by HHS in 2018. We note that HHS proposes to do this by incorporating by reference the guidance it promulgated in 2018 scaling back the substantive standards by which HHS assesses waiver applications for approval.³ This is impermissible as this document was previously published by HHS in the Federal Register; per 1 CFR §§ 51.7, materials previously published in the Federal register are inappropriate to incorporate by reference. This is in line with the Administrative Procedures Act's general requirement that the public is given an opportunity to comment on all substantive changes. By seeking to incorporate by reference a previously-published document, HHS is robbing individuals of an opportunity to comment on the substantive waiver approval standards it seeks to incorporate into its regulations for the waiver application procedure. At a minimum, if HHS wants to codify its 2018 waiver approval standards (which we oppose on the grounds below), it must do so by issuing a separate notice of proposed rulemaking with opportunity for comment.

States have used 1332 waivers – specifically those that have implemented innovative reinsurance programs – to lower costs and make coverage more affordable for people who need it most. While we support state innovation to ensure that coverage is affordable and accessible, we are concerned that the proposal to loosen the guardrails and protections for vulnerable populations will harm individuals living with pre-existing conditions and have negative individual and public health consequences.

We are concerned that the proposal to weaken the current requirement that a 1332 waiver ensure that the same number of individuals are *covered* by ACA-compliant coverage to only ensure that the same number of individuals have *access to* ACA-compliant coverage will exacerbate market segmentation, making ACA-compliant coverage more expensive for those who need it. The new access standard is compounded by a significant weakening of the coverage and affordability guardrails, allowing states to include plans that provide less than “minimum essential coverage” or that exceed ACA cost-sharing limits in the waiver as long as there is a comprehensive and affordable option still available.

This new approach will incentivize states to create a segmented market, using pass-through federal funding to increase access to cheaper, less comprehensive coverage, while individuals

³ State Relief and Empowerment Waivers, 83 FR 53575 (October 24, 2018).

with higher healthcare needs will stay in the ACA-compliant market. As we have commented before, we think market segmentation causes a double harm for people living with HIV, hepatitis, and other serious medical conditions: individuals may be drawn to cheaper coverage and end up in a plan that does not meet their healthcare or affordability needs; while individuals who choose an ACA-compliant plan because it's the best option for their healthcare needs may face steep premium increases.

Further, we note that HHS does not include a requirement that the impact of 1332 waivers be assessed across specific communities, including people with higher health care needs. This was an important part of the 2015 guidance on 1332 waivers and ensured that waivers would not be approved if they reduced coverage for a particularly vulnerable group, even if coverage under the waiver was comparable to coverage without the waiver in the aggregate. This type of assessment is particularly important to ensure access to HIV and hepatitis care and treatment. We have made significant progress in our nation's effort to fight and ultimately end these epidemics, but this progress has depended on the critical pre-existing condition protections included in the ACA. Specific evaluation of a waiver's impact on individuals living with higher cost health conditions is particularly important given the weakened coverage and affordability guardrails discussed in more detail below. Waivers that will cause disproportionate harm to individuals living with HIV, hepatitis, and other serious medical conditions should be rejected.

Premium Adjustment Percentage §155.130(E)

HHCAWG [previously opposed](#) the method by which HHS has calculated the premium adjustment percentage since Plan Year 2020 and urges HHS to withdraw this and return to its previous methodology. We reiterate our concerns in response to the adjustment to the premium adjustment percentage announced in the Notice of Benefit and Payment Parameters 2020 Final Rule: including Exchange premiums in the calculation of per enrollee premium will raise costs for millions of consumers, including by raising enrollees' out-of-pocket maximums and forcing enrollees to shoulder higher premiums. The previous methodology for calculating the premium adjustment percentage was put in place by HHS due to a recognition that individual market premiums in the ACA-compliant market would likely be unstable as insurers adjusted to new rules. Particularly in light of the recent regulatory changes expanding the availability of non-ACA-compliant forms of coverage, insurers are still facing considerable uncertainty as to market stability. In light of this uncertainty and the negative consequences this modification would have on people living with HIV, HCV, and other chronic health conditions, we urge HHS to withdraw this proposal and reinstate the premium adjustment percentage methodology used in 2019.

Special Enrollment Periods §155.420

Exchange Enrollees Newly Ineligible for APTC

We support the proposal to allow enrollees who lose eligibility for Advance Premium Tax Credits (APTCs) and become eligible for a Special Enrollment Period (SEP) to enroll in a Qualified Health Plan (QHP) with a lower metal level. We support applying this proposed policy

to all consumers who lose APTC eligibility and qualify for an SEP, regardless of the reason for their loss of APTC eligibility, and urge HHS to go even further by lifting all plan selection restrictions for all consumers who apply for coverage through an SEP.

The freedom to choose a plan that best suits a consumer's needs is critical for ensuring that consumers can maintain affordable coverage even if they lose eligibility for APTCs. Consumers who lose eligibility for APTC based on an income increase, for instance, may lose a significant amount of financial assistance without having gained enough income to continue to afford the coverage they selected when APTC was available to them. This is particularly true for individuals living with HIV, who have to navigate high cost-sharing for medications and therefore need maximum flexibility when choosing a plan that best balances their out-of-pocket costs and monthly premiums. HHS rightly acknowledges in its proposal that eligibility for APTCs significantly impacts consumers' coverage decisions, and that consumers shop for coverage based on premiums that are reduced by the APTC amount for which they were eligible at the time of plan selection. Additionally, Congress' intent in passing the SEP-related provisions of the ACA was to ensure that consumers can make changes to their coverage to best suit their needs when their circumstances change; limiting consumer choice when a consumer experiences such a change in circumstances undermines Congress' intent in allowing for SEPs in the first place. We therefore support this proposal as an important protection to ensure consumers—and especially those living with HIV and other chronic conditions who rely on continuous, affordable coverage for care and treatment, as well as those at risk for HIV or other chronic conditions who rely on their coverage for testing and other preventive care—are not forced to drop their coverage altogether due to income fluctuations that could make full cost coverage unaffordable.

HHS seeks comment on whether this proposal will increase the risk that consumers will change plans without taking into account potential disadvantages, such as additional out-of-pocket costs incurred when a consumer's deductible resets after switching plans. This is a potential risk any time a consumer switches to a new QHP mid-year, including one within the same metal level as their existing plan as is permitted under current policy. We believe that including language in eligibility notices and/or directly on the Marketplace website explaining this and other risks will help consumers make informed decisions about switching plans with knowledge of the trade-offs, and we encourage HHS to take all possible measures to ensure consumers are aware of these considerations when making decisions about their coverage.

While we appreciate this component of the proposal and generally support policies that increase consumer choice, we do not feel that this proposal goes far enough. We urge HHS to return to the pre-2017 policy of freely allowing consumers who qualify for an SEP to choose from any available plan, with no restrictions on metal levels, consistent with federal law. Prior to the Market Stabilization Final Rule, finalized in 2017, people eligible for an SEP were generally allowed to choose any available plan just as they would be able to do during the annual open enrollment period. This is consistent with the ACA's guaranteed availability requirement that requires issuers to accept any applicant for coverage. This is an important consumer protection because it gives consumers the flexibility they need to evaluate their coverage and adjust it when they or their family members experience significant life changes. The changes finalized in the

Market Stabilization Rule generally prevent people enrolled in individual market plans from switching to a different metal level during the year, while people who trigger an SEP that involves adding a dependent would generally only be able to add that dependent to their plan and not change plans themselves as was previously permitted. Limiting plan options for consumers eligible for an SEP is in conflict with the guaranteed availability requirements because it restricts plan options for people who are enrolled in an individual market plan, while allowing other people who come in during the year to freely choose the plan that best meets their needs.

The only restriction on plan choice authorized by the ACA is related to employer coverage—employers buying coverage through the Marketplace may select one coverage level to be made available to their workers, with workers then choosing any plan in that coverage level. The statute does not make any other exceptions to the very clear guaranteed availability requirements passed by Congress. Comments in opposition to this change in the proposed Market Stabilization Rule noted that, although insurers claimed there was a problem with people “buying up” their coverage during the year, there was no actual evidence that this was happening to a significant degree. Commenters argued that HHS acted on these claims to make major changes to enrollment rules that conflict with federal law and negatively impact consumers, despite the lack of evidence supporting that such changes were necessary. We echo these concerns now. By this time, after seven enrollment cycles, insurers should be able to adequately price for occasional shifts that current enrollees may make between different plans or metal levels during the year. We ask HHS to adopt the proposal to give consumers who lose APTC eligibility more plan choice, and further urge HHS to return to its pre-2017 policies by lifting all restrictions on plan choice consistent with federal law.

HHS states in its proposal that it is considering whether to allow consumers who lose APTC eligibility to choose from any lower metal level, or to limit consumers to choosing a plan from one metal level lower than their current QHP. We believe that placing such limitations on consumer choice undermines HHS’ reason for considering this change in the first place—to avoid situations where consumers lose APTC eligibility due to an income increase and are no longer able to afford coverage, because they lost a significant amount of financial assistance without having gained enough income to continue to afford the coverage they selected when APTC was available to them. HHS notes in its proposal that the average difference between a gold plan premium and a silver plan premium is 14 percent, while the average difference between a silver plan premium and a bronze plan premium is 34 percent. Therefore, a consumer enrolled in a gold plan who loses APTC eligibility may still be unable to afford a silver plan and should have the option to choose a bronze plan if this is what best fits their needs. The alternative in many cases will be to forego coverage altogether due to unaffordability, which is especially harmful to people living with and at risk for HIV and other chronic conditions who rely upon access to affordable, uninterrupted coverage. Limiting consumer choice also creates risk of adverse selection, because consumers with lower health needs are more likely to forego coverage if it becomes unaffordable, while individuals living with HIV and other chronic conditions will stretch their incomes as far as possible to maintain coverage.

HHS seeks comment on whether it should allow consumers who become newly *eligible* for APTC to have the option of switching to a plan with a higher metal level. We support such a change and disagree that it would lead to adverse selection by permitting individuals to change coverage levels in response to health status changes. Health status changes do not trigger SEP eligibility, nor do health status changes typically cause people to experience changes in their income that affect APTC eligibility. There is no apparent basis for assuming that a correlation exists between SEP eligibility and health status. To the extent that a consumer opts for a higher-cost plan upon gaining eligibility for APTCs because the plan they initially chose, based on their ability to afford coverage without APTCs, does not provide them with adequate coverage, this is a positive outcome from a policy standpoint and consistent with Congress' intent in passing the ACA because it means the consumer is now able to afford coverage that best suits their needs. It is a failure of policy that such a consumer was unable to afford adequate coverage in the first place. Rather than penalizing consumers for policy failures by forcing them to maintain inadequate coverage, the administration should promote policies that make adequate, affordable coverage available to consumers of all incomes.

Untimely Notice of Triggering Event

HHS proposes to allow consumers who did not receive timely notice of an event that triggers SEP eligibility and/or were reasonably unaware at the time that a triggering event occurred to select a new plan within 60 days of the date on which they knew, or reasonably should have known, of the occurrence of the triggering event; to allow consumers in this situation to choose the earliest coverage effective date for the triggering event that would have been available if they had received timely notice of the triggering event; and to apply these rules to off-Exchange plans. We support these proposals.

Cessation of Employer Contributions to COBRA as a Special Enrollment Period Trigger

Under current policy, consumers enrolled in COBRA coverage may be eligible for a loss of minimum essential coverage SEP if their employer completely ceases COBRA contributions and the consumer must pay full cost for their premiums. However, this may not be considered an SEP triggering event by issuers of off-Marketplace coverage or by state-based Marketplaces. Consumers who enroll in COBRA coverage have presumably lost their employment, making it even more challenging for them to afford COBRA continuation coverage premiums because, as HHS rightly points out, COBRA premiums are very costly and loss of employer contributions may render this type of coverage unaffordable for many people. HHS therefore proposes to make this SEP available throughout the individual market—that is, to expand it to off-Marketplace coverage and state-based Marketplaces—rather than only through the federally-facilitated Marketplace. We support this proposal as an important consumer protection, ensuring that people who lose access to affordable COBRA coverage are not forced to forego coverage altogether due to unaffordability. This is especially critical for people living with HIV and other chronic conditions, who may experience gaps in care and treatment if they are unable to afford coverage after losing their employment, as well as people at risk for HIV and other chronic conditions who rely on affordable coverage for testing and other preventive care.

This serves as a helpful example of a situation where allowing consumers to freely switch metal levels when they experience any triggering event is especially important. Under current policy, if one member of a family qualifies for a loss of coverage SEP because their employer ceased COBRA contributions, that family member may either join the QHP of a household member who is already enrolled in Exchange coverage or enroll separately in their own plan. Given that COBRA coverage is only available when someone loses employment, the entire family has likely experienced a significant change in household income and should have the flexibility to switch to a QHP that best fits their needs. CMS' proposals address this situation, but only to a point. We therefore support HHS' proposals to expand access to SEPs for consumers whose employers cease COBRA contributions, and again urge HHS to go even further by removing all limitations on consumer choice when individuals and families experience qualifying life events. Given the high unemployment rates during the COVID-19 pandemic, which is likely to impact the U.S. economy for the foreseeable future, policies that ensure uninterrupted transitions between coverage types when consumers lose employment or experience unexpected changes in financial circumstances are of critical importance now more than ever. Expanding access to coverage following employment loss by allowing consumers more flexibility to switch coverage if their COBRA becomes unaffordable, coupled with policies that lift barriers such as SEP restrictions, are necessary to ensure that no consumers fall through the cracks during public health crises and periods of economic downturn.

HHS states in its proposal that it is considering addressing situations in which an employer reduces, but does not completely cease, its COBRA premium contributions. HHS acknowledges that consumers may not be able to maintain COBRA coverage with a reduced employer contribution; we agree with this conclusion, and emphasize that inability to afford COBRA coverage can be especially detrimental to individual and public health if consumers living with or at risk for HIV and other chronic conditions are unable to access affordable QHPs when their COBRA costs become prohibitively high. HHS also points out that, although reduced employer contributions to *non-COBRA* employer-sponsored coverage do not trigger an SEP, COBRA is different from other types of employer coverage because COBRA is not subject to an affordability test for purposes of APTC/CSR eligibility and is typically more expensive than employer coverage. In other words, many consumers with employer coverage have *some* protection against exorbitantly high costs because they can become eligible for APTCs if their costs exceed a certain threshold, but COBRA enrollees whose costs become too high have no affordable options available to them. We would also add for HHS' consideration that consumers enrolled in COBRA coverage have lost employment, and their financial situations are therefore likely more fragile compared to consumers who experience increases in costs for employer coverage. We support allowing for SEPs in cases where a consumer's employer partially reduces COBRA contributions and encourage HHS to put forth such a proposal in the future.

HHS also seeks comment on whether it should adopt a threshold for the level of reduction in employer COBRA contributions that trigger an SEP. While we cannot provide comprehensive comments absent a notice of proposed rulemaking explaining how such a threshold would be developed and applied, we feel, at the very least, that HHS should take into account the fact that consumers enrolled in COBRA coverage have lost their employment and are therefore likely

experiencing financial vulnerability. We refrain from comment on the adequacy of the Internal Revenue Service's (IRS) threshold of 9.83 percent for evaluating affordability of employer coverage because HHS and IRS are not considering changes to the affordability test at this time; however, we feel that this threshold could be inappropriately high for evaluating COBRA affordability due to the financial challenges and uncertainty consumers already face following loss of employment.

Allowing an SEP for partial reductions in employer COBRA contributions would also be consistent with HHS' proposal to allow consumers who become newly ineligible for APTC to switch to a plan with a lower metal level—just as consumers shop for coverage based on premiums that are reduced by the APTC amount for which they were eligible at the time of plan selection, they similarly opt to enroll in COBRA coverage instead of a QHP based on the costs of that coverage at the time of enrollment. Consumers who enroll in COBRA coverage were eligible for an SEP based on loss of minimum essential coverage and could have chosen to enroll in a QHP, but instead chose to enroll in COBRA after evaluating the costs of these two options. But, unlike premium increases resulting from a consumer becoming newly ineligible for APTC, increased COBRA premiums due to reduced employer contributions are based solely on the employer's discretion and are not a result of an increase in the consumer's income; in fact, the consumer has likely experienced a *decrease* in income because COBRA eligibility is triggered by loss of employment. HHS' rationale for proposing to relax restrictions on plan selection for consumers newly ineligible for APTCS—that is, that consumers who lose eligibility for APTC may not be able to afford the coverage they selected when APTC was available to them—supports also allowing an SEP in cases where a consumer's COBRA costs change because of decreased employer contributions. The outcome is the same in that the consumer's coverage costs are different than they were at the time when they chose their plan and they must now pay much higher costs than they can afford, but their financial situation is likely even more fragile because they have lost employment instead of experiencing an income increase. We hope that HHS will consider expanding SEPs to consumers whose employers partially reduce COBRA contributions, and also consider allowing an SEP in the similar situation where a partial decrease in APTC may render existing coverage unaffordable.

Special Enrollment Period Verification

HHS proposes to require state-based Marketplaces to conduct SEP pre-enrollment verification for new enrollments effectuated through an SEP, and to require that Exchanges verify at least 75 percent of such new enrollments. We oppose this proposal because it erects unnecessary barriers to accessing coverage and urge HHS to instead focus on enrollment processes that facilitate, rather than hinder, enrollment. This is especially critical given the high rates of coverage loss during the ongoing COVID-19 pandemic, during which access to SEPs has been critical for ensuring that consumers, and especially those living with and at risk for HIV and other chronic conditions, remain insured during a public health crisis.⁴

⁴ "Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency," Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services (Nov. 2020), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report->

SEP pre-enrollment verification was proposed and finalized in HHS' 2017 Market Stabilization Rule, and arguments raised in comments opposing this change at that time remain salient today. HHS failed in its Market Stabilization notice of proposed rulemaking to produce data from industry or government sources to show whether and how often people ineligible for SEPs were nonetheless using them to access coverage, and fails again now to provide any evidence to support expanding this harmful policy that reduces access to coverage by needlessly delaying coverage start dates and erecting unnecessary barriers to enrollment. Data previously cited by insurers and analysts to show alleged widespread abuse of SEPs, based on the fact that individuals who enroll through an SEP have higher claims costs than those who enroll during the annual open enrollment period, has been found to have serious shortcomings.⁵ But, even if the full difference in claims costs identified several years ago between SEP enrollees and other enrollees stemmed from abuse, experts concluded that eliminating that differential would only reduce average individual market claims costs by around one percent because SEP enrollees are a small fraction of total enrollment.⁶ HHS does not provide any data showing that SEP pre-enrollment verification in the federally-facilitated Marketplace has been an effective policy for addressing these unsubstantiated claims, even though HHS ostensibly has three years of experience with SEP pre-enrollment verification through Healthcare.gov to evaluate its effectiveness. Nor does HHS provide any analysis of the impact that prior increases in SEP documentation have had on enrollment and consumer access. If HHS' concern is adverse selection, we suggest it reconsider imposing burdensome requirements such as pre-enrollment verification that create barriers to enrollment, because consumers with low health needs are more likely to forego coverage if enrollment becomes too burdensome. Furthermore, state-based Marketplaces already have flexibility to adopt SEP verification policies that fit the needs of their state, and HHS provides no evidence showing that this existing flexibility is insufficient to meet states' needs or that anything short of making SEP verification mandatory would be similarly insufficient. In fact, HHS does not state any clear discernible need for this policy change within the sparse four pages of its proposal, rendering it arbitrary and capricious in violation of the Administrative Procedure Act (APA).

HHS acknowledges that some state-based Marketplaces may be challenged to conduct accurate and timely verifications due to administrative burden and costs, and therefore proposes to allow states to request federal approval for alternative verification processes. But HHS undermines its purpose in allowing this flexibility by putting an arbitrary 75 percent threshold on SEP verifications, which could require states to expend unnecessary resources verifying more enrollments than necessary. We understand that HHS wishes to preserve and expand existing flexibility for Exchanges to decide which SEP types to verify and the best way to conduct

[Nov-2020.pdf](#) (finding that 485,000 consumers gained coverage through the loss of MEC SEP in 2020, an increase of 52 percent from the same time period last year).

⁵ Matthew Fiedler, "Trump administration's proposed change to ACA special enrollment periods could backfire," Brookings (Feb. 17, 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/02/17/trump-administrations-proposed-change-to-aca-special-enrollment-periods-could-backfire/>.

⁶ *Id.*

verification, but we do not see how an arbitrary requirement to verify 75 percent of new enrollments effectuated through SEPs accomplishes this goal. We say it is arbitrary because HHS provides no explanation whatsoever of how it arrived at this 75 percent threshold or any data to show how often Healthcare.gov currently conducts SEP verifications. This amounts to a failure to provide even the minimum information needed for the public to adequately weigh in on this proposal. HHS acknowledges that SEP verification may be administratively burdensome for state-based Marketplaces, but in the same breath proposes to implement a mandatory and arbitrary quota for how many verifications a state should conduct. Given the illogical nature of this proposal and the absence of any evidence showing that it is even remotely necessary, we are concerned that this proposal amounts to nothing more than a baseless strategy to curb enrollment during a global pandemic, when the need for accessible, affordable health coverage could not be more urgent.

HHS' proposal to expand SEP pre-enrollment verification to state-based Marketplaces and place a quota on how many verifications a Marketplace must conduct, in a rushed manner and without any discernible evidence showing the need for such a policy or the impact it will have on consumers, is arbitrary and capricious and exceeds HHS' authority. It also undermines the administration's ambitious goals to end the HIV epidemic by creating unnecessary barriers to access and deterring consumers with lower health needs from enrolling in coverage. We oppose this portion of the proposal in its entirety and urge HHS to focus its efforts on expanding access to coverage, especially during a global pandemic.

PBM Reporting § 184.50

Pharmacy benefit managers (PBMs) have an increasing role in the health insurance system and prescription drug benefit management. However, information on PBM operations is not transparent. In Medicare, PBMs are required to report on certain prescription drug distribution and cost data which provides insight into the role PBMs play, methods used, and revenue generated. The Proposed Rule would require PBMs to report on the same information they provide in Medicare, and that qualified health plan issuers must account for in the individual market. PBMs must report to the Secretary of HHS, as required by section 1150 A, the percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; generic dispensing rates; total amount and type of rebates, discounts, or price concessions that the PBM negotiates and the totals that are passed through to the plan sponsor; and the aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail and mail order pharmacies. HHCAWG supports this provisions and believes that requiring this reporting will provide some visibility and accountability of PBM operations.

User Fee Rates § 156.50

The proposed rule would cut the federal marketplace user fee by 25 percent, from 3 percent to 2.25 percent and would cut the user fee for state-based marketplaces that use the federal platform from 2.5 percent to 1.75 percent. We oppose this provision.

The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. As we stated in our opposition to the direct enrollment pathways above, access to unbiased navigation services is crucial to ensuring that people living with HIV are able to locate and enroll in the qualified health plans that best suit their needs.

The proposed rule's rationale for the cut is that the lower user fee would be sufficient to fund current marketplace activities. But current activities are inadequate. Under the current Administration, CMS has virtually ceased marketing and outreach and has slashed funding for Navigators, core marketplace functions funded by user fees. Rather than cutting the user fee, it should be *increased* to 3.5 percent (the level in effect prior to 2020) to restore outreach and enrollment assistance programs and to fund continued improvements to HealthCare.gov, including technological enhancements and improved customer service.

Thank you for the opportunity to provide feedback and for your thoughtful consideration of these comments. If you have further questions, please reach out to HHCAWG co-chair Phil Waters at pwaters@law.harvard.edu with the Center of Health Law and Policy Innovation, Rachel Klein and rklein@taimail.org with The AIDS Institute, or Aisha Davis at adavis@aidschicago.org with AIDS Foundation of Chicago if we can be of assistance.

Respectfully submitted by:

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ADAP Advocacy Association
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AIDS Alliance for Women, Infants, Children, Youth & Families
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AIDS Research Consortium of Atlanta
AIDS United
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APLA Health
Bailey House, Inc.
Black AIDS Institute
Center for Health Law and Policy Innovation
Communities Advocating Emergency AIDS Relief (CAEAR)
Community Access National Network (CANN)
Georgia AIDS Coalition
Harm Reduction Coalition
HealthHIV
HIV Medicine Association

HIV+Hepatitis Policy Institute
Housing Works
Legal Council for Health Justice
Michigan Positive Action Coalition
Minnesota AIDS Project
National Alliance of State and Territorial AIDS Directors
National Latino AIDS Action Network
National Working Positive Coalition
NMAC Positive Health Solutions of the University of Illinois
Positive Women's Network – USA
Prevention Access Campaign
San Francisco AIDS Foundation
SisterLove
Southern AIDS Coalition
The AIDS Institute
Thrive Alabama
Treatment Access Expansion Project
Treatment Action Group
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