



July 27, 2021

The Honorable Xavier Becerra
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Box 8016, Baltimore, MD 21244-8016

RE: CMS-9906-P: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Dear Secretary Becerra and Administrator Brooks-LaSure:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 133,500 family physicians and medical students across the country, I write in response to the [proposed rule](#) Updating Payment Parameters, Section 1332 Waiver Implementation Regulations, and Improving Health Insurance Markets for 2022 and Beyond, as published in the *Federal Register*.

The Affordable Care Act (ACA), and specifically the creation of the individual market, has improved access to the affordable, comprehensive, and continuous primary care services that family physicians provide.^{1,2} The AAFP firmly believes that everyone in the United States should have access to these vital services and therefore we remain committed to building upon the successes of the ACA.³ We are pleased HHS is proposing to repeal several harmful policies and instead makes several proposals to facilitate continuous coverage, as we [recommended](#) in a previous letter to President Biden.

Requirements for Navigators

The proposed rule would reinstate the requirement that navigators in federally facilitated exchanges (FfEs) provide information and assist consumers with certain post-enrollment issues. HHS specifically proposes to require that navigators help consumers file an appeal of exchange eligibility determination, apply for an exemption to maintain minimum essential coverage, reconcile premium tax credits with the exchange, understand basic concepts of health coverage, and make referrals to appropriate tax preparers. The AAFP supports this proposal.

A 2020 national survey found that consumers highly value enrollment assistance and 40 percent of those who enrolled in coverage with help said it was unlikely they would have coverage if not for consumer assistance.⁴ At the same time, nearly five million more consumers tried to find assistance but could not, likely due to previous cuts in navigator funding.⁵ These results clearly indicate the vital role of navigators. The AAFP is pleased that HHS restored needed funding for navigators and

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supports policies to improve access to consumer assistance. We agree with the Department that navigators are well-equipped to help enrollees understand the basic concepts of health coverage, including the primary and preventive care they can receive without cost-sharing and how to find an in-network primary care physician.

Exchange Direct Enrollment Option

HHS previously finalized the Exchange Direct Enrollment (EDE) Option, which allows states to opt out of using a single, centralized exchange (for most states, HealthCare.gov) and instead use only private sector entities to enroll individuals. Under EDE, private entities, insurers, web brokers, and agents and brokers, operate enrollment pathways where consumers would shop, select a plan, and enroll in coverage. While the exchange still has to maintain a website with various basic information and would be responsible for back-end enrollment processes, like conducting eligibility determinations and verifying applicant information, shopping and enrolling for plans would be done solely through private entities. The AAFP submitted [comments](#) strongly opposing EDE, citing concerns that this option would increase the number of uninsured individuals across the nation, erode affordable access to primary care, and negatively impact health outcomes.

The AAFP supports the proposal to repeal the EDE option and corresponding user fee and urges HHS to finalize it. The success of the COVID-19 special enrollment period (SEP) has again demonstrated the value of the exchange, with more than one million consumers enrolling in a qualified health plan (QHP). Even before the pandemic, most consumers enrolled in QHPs through the exchange – not through direct enrollment pathways. Maintaining a central portal for enrollment is needed to reduce the burden on consumers, avoid confusion or deceptive marketing practices, and ensure seamless enrollment for individuals eligible for Medicaid and the Children’s Health Insurance Program (CHIP), and promote affordable access to comprehensive coverage.^{6,7,8}

Open Enrollment Period Extension

Currently, the annual open enrollment period for all Exchanges is from November 1 to December 15. HHS is proposing to lengthen the open enrollment period by one month, with open enrollment ending January 15 beginning with the 2022 plan year. This would apply to both FFEs and state-based exchanges (SBEs). HHS notes that this extension would benefit consumers who qualify for marketplace subsidies and are auto-enrolled into coverage, as it would allow them the chance to change plans in the event their subsidy is reduced.

The AAFP supports this proposal and agrees that it would be especially valuable for low-income consumers that qualify for marketplace subsidies, as well as other underserved consumers. Evidence indicates that lengthening the open enrollment period increases enrollment. During the 2019 open enrollment period, SBEs with extended enrollment period showed an increase in plan selections while those with a 45-day open enrollment period had a reduction in plan selection.⁹

Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income No Greater than 150 Percent of the Federal Poverty Level

HHS proposes to codify a monthly SEP for qualified individuals or enrollees, or the dependents of qualified individuals, who are eligible for advanced premium tax credits (APTC), and whose household income is expected to be no greater than 150 percent of the federal poverty level (FPL).

The SEP would be available at the option of the Exchange to allow State Exchanges to decide whether to implement it based on their specific needs. Coverage for plans selected during the monthly SEP would be effective on the first day of the month following plan selection. HHS will also undertake extensive outreach and engagement efforts to promote enrollment and help ensure consumer awareness of existing special enrollment period for which they may qualify.

The SEP would be unique in that it would not be time-limited based on a change in an applicant's status or another qualifying life event. Qualifying individuals could enroll any time during the year based on their income or upon learning of their eligibility. The American Rescue Plan Act implemented enhanced APTC such that many low-income individuals are eligible for QHP coverage without needing to pay a premium after the application of APTC. HHS hopes that the ongoing nature of this SEP will bolster enrollment for the more than one million individuals who are currently eligible for a QHP without needing to pay a premium. HHS notes this SEP would be particularly helpful in ensuring continuous coverage for individuals who lose Medicaid coverage, including the many Medicaid beneficiaries whose coverage may be terminated at the end of the public health emergency.

The AAFP strongly supports the proposal to create a monthly SEP for individuals (and their dependents) who are eligible for APTC and whose expected household income is expected to be no greater than 150 percent of FPL. We have long [advocated](#) for federal policies that facilitate access to affordable, comprehensive health insurance coverage for all. This reoccurring SEP would increase enrollment opportunities for low-income individuals and ultimately enable them to receive essential primary and preventive care.

The AAFP agrees that the creation of this SEP will help individuals who lose Medicaid coverage once the continuous coverage requirement associated with the COVID-19 public health emergency ends. Ensuring continuous coverage will be particularly vital for individuals with chronic conditions and the growing population of patients experiencing post-COVID conditions. These patient populations often rely on prescription medications, care management and coordination, and other services to manage their symptoms and maintain wellbeing. Disruptions in coverage could result in poor outcomes for these already vulnerable populations and are associated with increased emergency department use.¹⁰

We also agree that this SEP could benefit individuals who lose Medicaid coverage 60 days after the end of pregnancy and need more time to enroll after the end of the SEP due to loss of minimum essential coverage. We note, however, that extending Medicaid coverage to at least one year after the end of pregnancy would more effectively ensure access to continuous care for postpartum individuals. For many patients, even seamlessly transferring from Medicaid to marketplace coverage could require them to change physicians due to varying provider networks, which would disrupt physicians' ability to monitor various conditions and the patient-physician relationship. Many will also experience coverage disruptions when trying to transition to marketplace coverage, which evidence indicates contribute to the high rates of maternal mortality among the Medicaid-eligible population.¹¹ Finally, we are concerned that postpartum individuals may forgo needed care due to cost after they switch to a QHP, while federal law precludes states from charging Medicaid beneficiaries for pregnancy-related services. The AAFP [urges HHS to issue guidance](#) to states on the new state plan option to extend postpartum coverage from 60 days to one year, as enacted by the American Rescue Plan Act.

Network Adequacy

HHS indicates in the proposed rule that the Department will implement updated federal network adequacy standards for QHPs in the FFEs in future rulemaking. The AAFP recommends that any federal standard ensure timely access to primary care physicians for plan enrollees across the lifespan. Virtual-only telehealth providers should not count toward a plan's network adequacy requirement. While telehealth services provided as part of a patient's medical home are high-value and can improve access to care, it is vital that patients have access to primary care physicians in their network that can meet any potential need for in-person services.

Segregation of Funds for Abortion Services

HHS proposes to remove previously finalized regulations which require insurers to send two separate bills: one for the coverage of non-Hyde abortion services and one for the coverage of all other services. **The AAFP opposed these regulations, citing concerns that they would preclude patients from access comprehensive care and result in coverage losses, and therefore supports the proposal to remove them.**

HHS would instead codify prior guidance that gave insurers flexibility in how to comply with the separate payment requirement in Section 1303 of the ACA and allows enrollees to pay for all types of coverage in a single transaction. HHS encourages states to minimize the burden on consumers and promote continuity of coverage. The AAFP supports the proposal to revert to and codify the prior policy.

Section 1332 Waivers

In the proposed rule, HHS outlines a new interpretation of guardrails for Section 1332 waivers. Section 1332 of the ACA permits states to apply for state innovation waivers to pursue innovative strategies for providing access to high value, affordable health coverage. HHS previously codified into regulation a guidance document from 2018 which outlines how HHS would apply Section 1332 of the ACA to determine whether applications for Section 1332 waivers will be approved. The AAFP opposed the 2018 guidance and proposal to codify it into regulation, repeatedly expressing concerns that the guidance bolstered the availability of non-ACA complaint plans and encourages states to undermine the Medicaid program. This runs counter to AAFP policy and, we believe, the intent of Section 1332 of the ACA. As such, **we support the proposal to rescind and remove any references to the 2018 guidance.**

HHS proposes to revert to the 2015 guidance for Section 1332 waivers. In evaluating Section 1332 waivers, HHS proposes to require that waivers: 1) provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) and offered through Exchanges; 2) provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as would be provided absent the waiver; 3) provide coverage to at least a comparable number of its residents as would be provided absent the waiver; and 4) do not increase the federal deficit. **This proposal is consistent with AAFP policy for ensuring equitable access to comprehensive, affordable health coverage and we urge HHS to finalize it.**

Thank you for the opportunity to provide comments on the proposed rule. Should you have any questions or wish to discuss our comments further, please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aafp.org or 202-235-5126.

Sincerely,



Gary LeRoy, MD, FAFAP
Board Chair
American Academy of Family Physicians

¹ Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D. Effects of the Affordable Care Act on Health Care Access and Self-Assessed Health After 3 Years. *Inquiry*. 2018;55:46958018796361. doi:10.1177/0046958018796361

² Schmittiel JA, et al. Improvements in Access and Care Through the Affordable Care Act. *Am J Manag Care*. 2017;23(3):e95-e97. Available at: <https://www.ajmc.com/view/improvements-in-access-and-care-through-the-affordable-care-act>

³ American Academy of Family Physicians. Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States. 2018. Available at: <https://www.aafp.org/about/policies/all/health-care-for-all.html>

⁴ Pollitz K, Tolbert J, Hamel L, Kearney A. Consumer assistance in health insurance: evidence of impact and unmet need. Kaiser Family Foundation. August 2020. Available at: <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>

⁵ Ibid.

⁶ Straw T. Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal. Center on Budget and Policy Priorities. 2020. Available at: <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal#:~:text=Section%201332%20allows%20a%20state,known%20as%20pass%2Dthrough%20payments.>

⁷ Straw T. "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities. 2019. Available at: <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

⁸ Government Accountability Office. Private Health Coverage: Results of Covert Testing for Selected Offerings. 2020. Available at: <https://www.gao.gov/assets/710/708967.pdf>

⁹ Schwab R and Corlette S. ACA marketplace open enrollment numbers reveal the impact of state-level policy and operational choices on performance. The Commonwealth Fund. April 2019. Available at: <https://www.commonwealthfund.org/blog/2019/aca-marketplace-open-enrollment-numbers-reveal-impact>

¹⁰ Sommers and others, "Insurance Churning Rates for Low-Income Adults Under Health Reform"; Eric T. Roberts and Craig Evan Pollack, "Does Churning in Medicaid Affect Health Care Use?", *Medical Care* 54 (5) (2017): 483-489, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5548183/>.

¹¹ Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Available at: <https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf>