Ref: 2021-13993 CMS Comment Period related to

Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS. Department of the Treasury.

Dear Secretary Becerra, Deputy Assistant Secretary Mazur, and the entire staff involved with research and development of this proposal,

I would first like to say thank you for your efforts to address the needs of the broad market that the PPACA looks to serve. This document lays out a clear plan to fill regulatory holes within current frameworks afforded to consumers.

FULL DISCLOSURE:
Currently we sit on the CMS Alpha Broker Workgroup, Pennie (Pennsylvania's Exchange) Policy and Legal Workgroup as an outside voice for the consumers in the markets we serve. At the trade level we sit on the Strategic Development committee for the Central Pennsylvania Business Group on Health as well as have active seats as the legislative chair for the Central Pennsylvania chapter of the National Association of Health Underwriters(nahu.org) and the Pennsylvania State Level Chair for the Health Agents for America(hafamerica.org). Any and all comments are expressly those of the writer and should not be construed as coming from any of the above organizations, nor should they be used as precedent for future litigation. Our goal with today's comments are to be general in nature and to offer potential considerations as future frameworks are adopted.

OUR WHY:
Many of the best organizations are founded based on personal events, and PA Health Advocates (PAHA) is no exception. Founder and Principal, Joshua Brooker received a big surprise along with the birth of his first child. The insurers double-billed him on the premise his oldest son was born in a different plan year (1/1) than his mother was admitted (12/31). Out of frustration, and lack of advocacy, PAHA was formed. With more than 10 years in the industry, serving the group, individual, and Medicare markets, PAHA is focused on making things much less complicated and advocating for our clients. We are focused on helping sidestep common pitfalls and assist in claims advocacy when things just are not working right. Additionally, in 2020 we create a separate entity, Helping Health, Inc. as a 501(c)(3) nonprofit to serve constituents at the height of covid with "Application to Approval" support to help consumers navigate CHIP and Medicaid. Finally, we are raising funds for a digital system, SnapHealth, that looks to address the next phase of healthcare regarding SDOH, Interoperability, Health Literacy, and Price Transparency initiatives.

SUMMARY OF TOPICS:
This comment will focus on the following topics addressed in 31 CFR Part 33:

1. Navigators
    a. Enrollment responsibilities
    b. Post Enrollment Duties
    c. Conflicts of Interest
2. SEP/OEP
    a. Extension of Open Enrollment
    b. 150FPL SEP
3. Section 1332 Waivers and Exchange DE
4. Equity
    a. Health Literacy
    b. Racial Equity

OPENING OBSERVATIONS:
86 Fed. Reg. 35,157 (July 1, 2021) – At the core, this document explains that Executive orders EO14009 and EO13985 prompt swift action to expand access to high quality healthcare to the entire population with an emphasis on underserved and uninsured communities. We agree with this premise. That said, we have as much an access problem as we do a branding problem. Day to day conversations with constituents has revealed that those previously uninsured could not believe that the PPACA and ARP have created access to $0 options.

BACKGROUND:
Consumer confidence: Mass marketing in an already cluttered marketplace creates customer confusion and decreased confidence. Ad spend at the government, insurer, and broker levels during OEP annually has continued to grow and platforms such as Google ads have begun requiring proof that an advertiser is properly licensed to market plans on their platforms. Annual changes to which plans are available, APTC amounts, APTC penalties come tax season, and Health Literacy has set the tone that this is not a place to DIY. As gross plan premiums raise higher and higher and APTC's follow suit, a consumer mistakenly pulling from an IRA could cause a $20,000 bill from the IRS come reconciliation. Annuity producers and Financial Advisors are not trained on the impact of MAGI on APTC eligibility, adding another wrinkle to this discussion. For consumers, the real need is brick and mortar representation through CACs/Navigators, and Agents/Brokers.

Markets: Beyond income, we tend to see five markets that interact with individual health insurance.

Small Groups
For groups under 50 employees, we have seen annual evaluations of employers considering traditional group benefits vs. HRA options (QSEHRA/ICHRA) vs. no benefit at all. Since these groups are not

Applicable Large Employers, they are generally not required to offer benefits. However, many of these groups repeatedly face questions during hiring and retention activities that involve the question "What benefits do you offer?" Benefits is a broad term, which gives them flexibility to cover via HRA or ancillary benefits. These groups struggle to keep up with large employers. The solution originally floated to employers was SHOP, a system directed to give a similar credit to the APTC for employers that offer group health plans through a Small Business Health Options Plan in their state. The challenge is many states have ZERO SHOP options available. And, as HHS cited in the "HHS Notice of Benefit and Payment Parameters for 2019" report, as of the report less than 39,000 people were covered by SHOP. https://www.federalregister.gov/d/2018-07355/p-655 Considering the loss of this benefit, small employers have three options:

1. They cover 50% of a standardized rate that is mandated for groups fewer than 50 employees. This plan offering, if satisfying MEC and Affordability testing, forces employees to take benefits that are more expensive then PPACA individual plans, and/or subject their families to the family glitch where these members go uninsured because the employer benefit is unaffordable (glitch does not account for family member premiums when testing for affordability) AND the marketplace is unaffordable without APTC availability.
2. They offer an ICHRA or QSEHRA benefit. This option gives greater flexibility for individuals to opt out of HRA benefits in lieu of better APTC options through the ACA. That said, this can cause 105(h) discrimination issues when Rank and File employees opt out of the HRA and only executives who do not get access to APTC's take the HRA.
3. Offer Nothing. Forgoing any benefit allows the employers to free up cashflow for other fringe benefits. This could also allow employees access to the full extent of ACA benefits including APTC and CSR's. Additionally, individuals on the exchange are more likely to be routed to Medicaid and CHIP benefits through the no wrong door process. Brokers and employers do not necessarily recommend CHIP or Medicaid as a viable option.

Regardless of the offering, this group of individuals often has the largest pool of straight forward W2 income with minimal Data Matching Issues since income does not routinely fluctuate. This group is also best primed for APTC since their stable income causes less strain on the system both during OEP and tax filing time with preparers.

Self Employed Individuals and Retirees

Although these two markets are separate, they do face similar challenges when it comes to projecting MAGI and reporting accurately to both their Exchange as well as the IRS. Since MAGI is often a snapshot of income on December 31st of the year you are seeking coverage, fluctuations in income require careful projections to ensure individuals do not owe large sums to the IRS. Since the beginning of the ACA, the largest feedback we have gotten from Accountants is (a) We need a 1095-A form to file their federal return. (b) They are frustrated that the MAGI was way off base.

Examples (Names changed to Client 1/C1 and Client 2/C2 to protect identity)

1. C1 and C2 own a small retail company. They bring in about $500,000 a year from sales of

products. They called the FFM and were told their income was too high for APTC. They spoke to brokers who reiterated the same message. After looking at their prior year return, it was evident the $500,000 they "bring in" were gross sales. After deductions for cost of materials, operations, and other valid costs of doing business, their net income was $55,000 of take home. They received over $18,000 in APTC the following plan year by providing better AGI data to the broker.

2. C1 and C2 had retired at age 58. They had a comfortable nest egg of about $1.2 million but were referred because their broker indicated they were spending approximately $40,000 per year between their off-exchange plan and out of pocket costs. He was concerned that over the next 7 years the individuals would exhaust $280,000 in their retirement pool which would jeopardize their ability to maintain their lifestyle through retirement without running out of assets. After a quick inspection they paid many of their ongoing expenses from nonqualified savings and only a little bit out of Traditional IRA assets. We were able to get them APTC's they were previously unaware of.
3. C1 was a Pastor for a local congregation that walked into a captive insurance agency (to be unidentified) who indicated his income was too high for any kind of help. He was paying over $1,200 per month. He was also unaware that of the $60,000 he was bringing in, $20,000 of housing allowance offered by the church was not countable as income. We were able to get him in a plan that covered him and his wife for $180 per month and his kids on CHIP for free.

I can continue with these examples time and time again because MAGI is a careful balance of what and when. Self employed individuals and retirees do not necessarily understand that this is a future projection of income and that is after business deductions and before personal. They also often need an advocate to represent them on this side of the code both with their financial advisors and accountants. This eases the burden for all stakeholders involved. We have "joked" that estimating APTC is a matter of projecting income in November and checking if you were right over 16 months later when your CPA goes to file. We feel that this support should fall outside of the scope of CAC's, Navigator's, and call centers since brokers have additional training and regulatory oversight with the Department of Insurance.

Transitions

These include but are not exclusive to:

1. Someone turning 26 and being ejected from a parent's plan
2. SEP's due to individual changes to household size, income, location, or job status
3. Retirement events where a spouse one may age into Medicare and the pre 65 spouse must weight COBRA to individual plans.

Each of these transitions can add a bit of complexity to the system. If someone is retiring, an assister must determine if they would be better suited for PPACA plans based upon annual MAGI, or Medicaid tied to recent income reduction. Neither system is flawless and having a person take in these variables further helps the consumer walk down the right road.

Large Group Employee DIYers
Large group DIYers are employees who come from larger companies that think "there must be a better option then my employers plan." They tend to be faced with group plan options that exceed their budget to provide adequate insurance for their spouse and/or family. This group is more likely to use unconventional sites that provide subpar solutions, they may consider faith based or short-term limited duration options, or worse, they could self-attest that their employer plan is unaffordable through a marketplace. Self-Attestation opens them up to APTC's they are not actually eligible for. This is a big cause for concern since, as previously mentioned, there is a lag between receiving APTC's and reconciling them. They often do not realize that "Affordability" is not a feeling, rather it is a key test with a clear framework they must pass. Because of the penalty ALE's face for not offering MEC, they are quick to dispute affordability charges.

We hope this background sets a clear framework as to the thought process behind our recommendations.

RECOMMENDATIONS

DEMOGRAPHICS
86 Fed. Reg. 35,157 (July 1, 2021) Regarding Statement "of the 30 million uninsured, half are people of color" Do we have more demographic information? I reviewed the 2019 CDC documents, and it does not seem to account for Faith Based or Short-Term options. Nor does it consider if someone is offered employer coverage, but it is unaffordable at the household level, not just employer level. Consider reviewing infrastructure of report.

SEP for 150FPL
86 Fed. Reg. 35,162 (July 1, 2021) Regarding SEP requirements for Insurers for off exchange plans. I agree with your proposal that 147.102(b)(2)(i) should be added. Considering this provision is to increase access to APTC, requiring an SEP for off exchange plans does not really address that need.

NAVIGATORS
86 Fed. Reg. 35,163 (July 1, 2021) Regarding Navigator Program Standards – We feel that, as discussed above, quality CAC's, Navigators, Agents, and Brokers already assist consumers with many of these topics discussed. We do see that setting standards would push laggards to the level they really need to be at to help the markets they serve. That said, we do want to address concerns related to a Navigators responsibility related to medical claims appeals, referrals related to Taxes, and grant funding.

Coverage Claims Appeals: Outlined on page 35,165, it is indicated "Navigators may help consumers obtain assistance with coverage claims denials." This statement needs to clarify if the reference to "coverage" is to the plan as a whole or to individual medical claims. If the assertion is that Navigators are involved with medical claims support, there needs to be further guidance that would clarify Navigator Authority as Authorized Representatives. Additionally, would their authority extend to referring a client to a hospitals "Financial Assistance" application, facilitating said application, and/or representing the consumer.
I feel this needs to be fleshed out before extending these powers to Navigators.

As mentioned prior: Navigators serve a key role in the straightforward W2 markets and assisting with Medicaid and CHIP. That said, according to the "Agents and Brokers in the Marketplace" piece released by CMS and HHS, in 2020 Navigators have accounted for only 31,200 enrollments compared to 3,962,735 applications processed by brokers. If funding concerns are considered, even in plan year 2017, Navigators addressed 76,956 enrollments compared to brokers still at 3,657,103. Brokers have continued to provide support at these levels with zero compensation for Medicaid and CHIP, ineligibility for grants for these markets, and in several cases zero compensation from insurers. The problem we see is that the proposals tend to look at "Navigators" and "Insurers" where brokers are an extension of the insurer. In a captive agent system where the agent is employed by the company and is paid a form of salary plus wages, I can see where this may be confusing.

The reality is there is a third category. It needs to be seen as this third category. Independent brokers often work in multiple markets, represent multiple carriers, and can even serve multiple states. They operate daily to reduce conflicts of interest and try to provide as wide a net of options as is possible to address the needs of the consumer. My experience across the panels and trade groups I affiliate with is more and more brokers operate with this ethical code. This third category of independent brokers do much of what is proposed and then some. We coordinate with tax professionals. We work with congressional leaders regarding complex cases. We work tirelessly to work within the framework given and provide insight to change policy where necessary (this is case in point.) Establishing this third category that moves non captive contracts outside of the MLR requirements would encourage insurers to push to non-captive agreements and help brokers be adequately compensated for the time and effort put it both during enrollment and post enrollment support.

86 Fed. Reg. 35,164 (July 1, 2021) Your document references "Navigators would be expected to familiarize themselves with… IRS Publication 974 Premium Tax Credit, and relevant FAQs, and to refer consumers with questions about tax law to those resources" For illustrative purposes, just because I gave you the link for this textbook: https://open.umn.edu/opentextbooks/textbooks/370 doesn't mean you all of a sudden understand Calculus, Differential Equations, or Integration. That said, providing an IRS publication is not enough to protect consumers. 1. These documents help guide professionals more than offer bite sized support for consumers. 2. Consumers need context and English. If navigators cannot be expected to "Interpret" the tax code, then how do you expect consumers to? Further investment needs to go into health literacy initiatives digitally, and adequate print materials for enrollers to request from CMS and distribute to clients who lack adequate digital access.

86 Fed. Reg. 35,164 (July 1, 2021) also indicated Navigators should still assist consumers aged 30 with filing for exemptions. The Catastrophic plans were originally designed to encourage people under 30 who were healthy to at least pick something. These plans are NOT high-quality options which you addressed in your summary was of most importance. We recommend striking 155.305(h) and instead setting a better framework for Short Term Limited Duration Plans those states can adopt. If a consumer is purchasing catastrophic plans as a just in case measure, STLD's like those offered by Golden Rule, National

General, or IHC, offer more affordable options to consumers with often lower copays, deductibles, or coinsurance. According to the Kaiser Family Foundation, 2021 Catastrophic enrollments accounted for less than 1% of total enrollments. This should not be a focus of brokers or Navigators.

The 80 million in grant funding should also be made eligible on a per enrollment basis for brokers who assist in Application to Approval initiatives with Medicaid and CHIP. Navigator and Broker involvement in the Medicaid process reduces confusion for consumers and increases the likelihood applications are submitted properly without gross follow up for documents. With bulk processing of enrollments, our team can anticipate the types of requests a case worker will need, and proactively send them along with the application. This helps expedite approvals and ensures lower attrition compared to low-income individuals who give up due to confusion or delays. Compensation to brokers also helps with conflicts of interest where brokers do not bother with training or honing skillsets around CHIP and/or Medicaid since they are not compensated for that line of work. For brokers to effectively serve their community, and with brief OEP windows, brokers may not assist with Medicaid and CHIP, or may be forced to hire additional staff to cover all client needs. Not assisting hurts consumers who need a local resource and hiring staff for pro bono work increases overhead and jeopardizes the sustainability of these brokers in the community. For example, our firm went from 1-5 Medicaid applications per month pre COVID to up to 15 – 20 per month during PY2021 OEP. These applications are longer, always require Data Matching follow up and are uncompensated time. We resorted to creating a non-profit to try to raise grant money from foundations and government entities to continue our work. Other agents are not doing that, nor should they have to simply help people of low means navigate the financial side of healthcare.

Exchange DE
86 Fed. Reg. 35,166 (July 1, 2021) proposes removal of 155.221(j) and repeal of the Exchange DE option. Considering the FFM already has a framework for DE and EDE, we do not see the administrative burden regards to passing on regulations to SBM's. We would suggest EDE partners must be approved federally to operate in any SBM. This would ensure security and compliance related to PII/PHI is set to federal standards. It would also decrease the administrative burden on states as well as EDE vendors who would be required to certify one state at a time vs. the federal standards.

You indicated since finalizing 155.221(j) under part 1 of the 2022 Payment Notice Final Rule, that CMS has received little feedback from states regarding interest in Exchange DE. Looking at the 11 states we operate in, Several SBM's, this was dropped on April 30th, 2021, and states were a bit preoccupied trying to Implement ARP regulations for APTC expansion, and Unemployment waivers. Even though this may be on their radar, lack of interest now should not be construed as lack of interest ever. The prospect of a lower user fee in conjunction with increased channels for consumer enrollment should be attractive to states. At the FFM level, EDE does help reduce consumer reliance on operational resources like call centers and healthcare.gov access. Instead, brokers who assist in enrollment through an EDE becomes the point of contact for the consumer and has a system for tracking enrollments. Since much of insurance

is relational with the person assisting the consumer, EDE partners have innovated to allow brokers to use tools beyond the standard exchange. These include immediate ability to download 1095-a's, CRM functionality to track Data Matching and service requests. Ability to notate files to track call notes. As we move further and further toward interoperability between patient, provider, payor, and assister, EDE's are better suited to create systems addressing market needs.

Because of this, we are asking you maintain your stance with 155.211(j). If you have received little response as of now, then this should cause little impact in the near term. Having this specifically codified shows the intent of CMS to extend this benefit to SBMs.

86 Fed. Reg. 35,168 (July 1, 2021) "we are also considering whether approaches such as enhanced noticing…" is referenced in the middle column toward the bottom. Each year insurers provide an "estimate" of the upcoming plan year premiums for auto-reenrollments. HHS suggests an SEP for auto enrollment who are surprised their premiums went up. We really need to get rid of the surprise in the first place. Insurer notices should be superseded by a plain language statement that says something to the effect of, "This document can ONLY illustrate the full cost of your current plan in the coming year. The second component of reducing that full cost by the premium tax credit does change each year. Factors including the addition or subtraction of plans in your county, or rate changes to specifically silver plans available in your county may cause you to pay more or less than the figure quoted." Otherwise, these notices do more harm than good.

86 Fed. Reg. 35,170 (July 1, 2021) You reference a concern regarding adverse selection if FPL150 SEP's would cause enrollees to hop plans or add and drop as medical needs arise. You rationalize that "enrollees…will likely be deterred because such a change will generally mean they lose progress they have made toward meeting their deductible and other accumulators." Reality, with 94AV Silver plans, many have such a low deductible that they are not really deterred from moving plans. That said, due to healthcare literacy limits, they are likely to change plans if and only if they discover provider inadequacy or high prices for rx or provider services. Proper support from a broker/navigator coupled with new price transparency laws should help consumers get plans right the first time.

86 Fed. Reg. 35,171 (July 1, 2021) The middle column requests comment on enrollments motivated by $0 premium plans. If the concern is that someone would hop on and off as medical need arises, maybe instead of banding by metal tier, you could make reenrollment captive to carrier. Hence, someone could have a silver plan with CSR's and look to drop the plan due to premiums…the enroller could suggest moving to a $0 premium bronze plan at the same carrier. This would ensure continued premium to the carrier and assist with adverse selection risks. Moving down a metal level would also reset deductible which would help carriers recover from bad actors that are looking to hop in and out only when they need services rendered.

86 Fed. Reg. 35,173 (July 1, 2021) Since a large majority of plans are APTC eligible, the user fee

seems to be a moot point. According to KFF (https://www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) the outlay of APTC for 2020 was over $50 Billion dollars. So, the FFM paying APTC's and then recouping 2.25 or 2.75% of premiums just seems like taking money out of one pocket and putting it in the other. I think the larger question is how do we reduce plan premiums, thus reducing the APTC outlays?

86 Fed. Reg. 35,175 (July 1, 2021) You reference amending 156.115(a)(3) to include mental health and substance abuse benefits in EHBs. We agree this is an important step. Especially through this pandemic, mental health has evolved from a closeted discussion to a major priority for individuals, employers, and physicians alike.

We want to thank you for reading our feedback and welcome any follow up discussions or requests for clarification.

Thank you,

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Principal

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