July 28, 2021

Administrator, Chiquita Brooks-LaSure  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

Re: RIN 0938-AU60; CMS9906-P: Comments on Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Dear Administrator Brooks-LaSure,

The I Am Essential coalition is pleased to see many of the provisions included in the Updating Payment Parameters proposed rule. We appreciate the opportunity to share our feedback and perspective as a broad coalition of organizations representing millions of individuals with serious and chronic conditions that is dedicated to protecting essential health care needs. The Affordable Care Act (ACA) has played a pivotal role in expanding coverage and guaranteeing essential health benefits for people living with serious, complex, and chronic conditions, and we look forward to working with you on ways to strengthen the program and restore the integrity of patient protections under the law. We believe that health insurance must be structured to meet the healthcare needs of people with serious and chronic conditions at all times, but especially through the ongoing COVID-19 pandemic. This letter offers comments stemming from our unique insight as individuals for whom continuity of care, accessibility of comprehensive coverage, and affordability of life-changing and life-saving medications are truly essential.

**Navigator Program and FFE User Fees**

Navigators serve an important function, conducting outreach and providing necessary assistance to vulnerable and underserved populations including patients with serious and chronic conditions, which is vital to the operation of the Marketplace. In particular, navigators are valuable in helping new enrollees, people with specific medical needs, and in situations of complex eligibility. As a result of the public health pandemic and the long-lasting economic fallout, the navigator program and navigators will be instrumental in assisting people through the transition to the ACA market and during the post-enrollment process. Expanding the required duties of navigators will ensure people are well-informed about their health insurance and well-equipped to access health care services they need.

To sufficiently support the increased demand for navigators, and to restore other outreach and marketing activities, I Am Essential recommended in our December 2020 comments that the federally-
facilitated exchange (FFE) user fee should not be reduced, as proposed, but increased. Navigators have unfortunately endured severe underfunding as a result of cuts to the program and reductions to the user fee. The program in total saw funding cuts amounting to 84% since 2017. I Am Essential supports the proposal to increase the user fee to 2.75%, reversing the previously suggested reduction, infusing the navigator program with funding to support critical outreach services. Together with the June announcement of a historic funding opportunity of $80 million, the user fee increase will provide financial stability to the program so that navigators can reengage people in underserved communities, improving access to health care coverage.

**Enrollment Opportunities**

Since the launch of the ACA Marketplaces, there has been a continuous demand for Marketplace-based health insurance by Americans. Recent enrollment reports show that given the opportunity, people will enroll in coverage. Between February 15th and July 14th, more than 2 million people enrolled in a health plan through the special enrollment period (SEP) granted in the wake of the COVID-19 pandemic. This demonstrates the need for expanded enrollment opportunities, both during the annual open enrollment period (OE), and through SEPs. I Am Essential supports the proposal to lengthen OE by one month, beginning with the 2022 plan year and for future years. Shopping for a plan and enrolling can be overwhelming. Individuals who were previously enrolled and have been auto-reenrolled in a different plan also may not have had time to fully process the impact the change will have on their health care. Extending the allowable time to select a plan will help all consumers evaluate their options and select an appropriate plan. Additionally, universally requiring on-exchange and off-exchange plans to adhere to these dates is also important as consumers must have sufficient time to evaluate the plans to find one that best fits their health care needs, regardless of insurance market. Finally, we encourage CMS to ensure that the federal OE dates constitute a minimum number of days; states should be allowed to have longer OE periods to suit their states’ needs.

Additionally, creating an on-going opportunity for individuals eligible for advanced payments of the premium tax credit, with incomes below 150% of the federal poverty level to access health insurance through the proposed monthly SEP will help the most vulnerable of individuals. As the world continues to adjust to a new reality and the economic crisis continues, it can be expected that many individuals and families will experience fluctuating financial circumstances for years to come as the job market stabilizes. This SEP will help the 1.3 million people enroll in coverage that are uninsured; many of whom report that the reason for remaining uninsured or underinsured is due to the high cost of health insurance. Chronic diseases and serious illness know no boundaries such as income, race, or ethnicity and is often compounded by those factors; this SEP will help to address issues of health equity and improve access to health care.

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Concerns about adverse selection in the Marketplace can be allayed by data from state-based exchanges that have implemented similar enrollment policy changes. Massachusetts has not reported an imbalanced market despite offering a more generous income-based SEP that allows people with incomes up to 300% FPL (about $36,000 for an individual or $75,000 for a family of four) to enroll in marketplace coverage year-round. And in states that implemented COVID-19 SEPs, data suggests that making it easier to enroll in coverage has attracted younger and healthier people, thereby balancing potential adverse selection.\textsuperscript{4,5} Extending open enrollment and providing new opportunities to enroll year-round will greatly benefit people and help reduce the number of uninsured.

**Exchange Direct Enrollment and Section 1332**

I Am Essential is pleased to see in the proposed rule that CMS would repeal the provision outlined in the 2022 NBPP that would have facilitated states’ transition away from the centralized HealthCare.gov exchange for enrollment purposes. States would have been able to delegate control of the enrollment process to commercial entities without establishing their own health insurance exchange, undermining a core feature of the ACA (one-stop shopping), decreasing access to health insurance, causing consumer confusion, and increasing the likelihood that patients with serious and chronic conditions will end up with sub-par coverage. By maintaining the integrity of the “no wrong door” policy that ensures consumers can compare plans and determine eligibility for premium tax credits or Medicaid in a streamlined manner, CMS will take away the burden that would have forced consumers to navigate a complex constellation of provider services and sites.

The 2022 NBPP moved to codify 2018 HHS guidance that would have weakened the guardrails that lie at the heart of Section 1332, allowing states to skirt requirements that protect vulnerable populations.\textsuperscript{6} This proposed rule would reestablish the guardrails as intended by the ACA, originally designed to promote innovation and allow states to pursue individualized approaches to expanded coverage.

Under the previous rule, HHS could have approved 1332 waivers that put vulnerable consumers, including those with chronic health conditions like HIV, epilepsy, multiple sclerosis, mental illness, lupus, and other serious conditions, at risk. However, by keeping in place the requirement that waivers cover at least as many people, with coverage at least as comprehensive and affordable as would be the case without the waiver, without increasing the federal deficit restores the patient protections that are of the utmost importance for I Am Essential.

**Expansion of Essential Health Benefits and Prescription Drug Coverage**

In addition to the other comments we have made here, we urge CMS to take action to improve prescription drug access in Marketplace plans. Currently, plans sold on the Marketplace are only required to cover the greater of one drug per class or the same number of drugs in each category and class as the EHB-benchmark plan. We urge CMS to strengthen the minimum requirement to cover at


At least 2 drugs per class, plus all or substantially all drugs in certain protected classes, guaranteeing people in Marketplace plans a prescription drug benefit on par with Medicare’s Part D benefit.

The Medicare Protected Classes policy was established to ensure that people with certain very serious and complex conditions have full access to the drugs they need to control their conditions. For these classes of “clinical concern”, medications are not interchangeable and access to the correct medication is a matter of life and death and, in some cases, public health. The Protected Classes benefit in Medicare was designed to “to mitigate the risks and complications associated with an interruption of therapy” for these very high-need patients. We believe that adopting a similar benefit in Marketplace plans could help guard against discriminatory benefit design and adverse selection.

The people we represent often need multiple, carefully managed medications to treat their conditions. People with complex conditions must work closely with their doctors to find the best treatment regimen, which may need to be changed over time or updated to assess the effectiveness of innovative therapies that are introduced into the marketplace. Medications can also become ineffective or produce complications over time, specifically in the case of enrollees using antiretrovirals to treat HIV. People facing complex medical issues must be able to access the full range of treatment options.

For example, for people living with epilepsy and seizures, there is no “one size fits all” anticonvulsant, and the response to anticonvulsants can differ between seizure type and be different from person to person. Many people take multiple anticonvulsants as part of their regime, so only covering one drug per class is far from sufficient. In one study, seizure-free individuals who had their drug switched had a 16.7% rate of seizure recurrence at 6 months, compared to 2.8% among people remaining on the same drug.8

According to the American Cancer Society Cancer Action Network, cancer care also requires specialized treatment, and medications to treat cancer are not therapeutically equivalent to other products within the same class. In order to increase the likelihood of successful cancer treatment, enrollees need access to cancer treatments that are as targeted as possible.9

HIV specialists have stated that there are “many important considerations, including the person’s adherence to medications, drug resistance, drug-to-drug interactions, concomitant medical conditions and side effect profiles [are] taken into account when choosing the best regimen…. it’s medically crucial to have all options on the table when prescribing and to be able to start those drugs quickly, with no barriers to access.”10 These unique biological and circumstantial considerations are true when

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7 Prescription Drug Benefit Manual, Ch. 6 § 30.2.5
approaching every HIV patient’s treatment; however, each variable becomes even more critical for those that have been on treatment for an extended period of time and those with comorbidities. We urge CMS to take greater action to ensure prescription drug coverage in the marketplaces is adequate by ensuring the minimum of two drugs per class and coverage of all or substantially all drugs in protected classes.

I Am Essential is dedicated to strengthening the ACA to ensure patients with serious and chronic conditions have access to and can afford their health care. This proposed rule provides reassurance to those who have high health care needs who rely on the patient protections guaranteed in their health plans.

Thank you very much for your consideration of our comments. Should you have any questions, please contact: Rachel Klein, Deputy Executive Director, The AIDS Institute, rklein@taimail.org; Laura Weidner, Vice President, Government Relations and Advocacy, Epilepsy Foundation, lweidner@efa.org; or Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance on Mental Illness, asperling@nami.org.

Sincerely,

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AIDS Alliance for Women, Infants, Children, Youth & Families
American Autoimmune Related Diseases Association
American Kidney Fund
Arthritis Foundation
Cancer Support Community
Community Access National Network (CANN)
Consumers for Quality Care
Dysautonomia International
Epilepsy Foundation
GLMA: Health Professionals Advancing LGBTQ Equality
Hemophilia Federation of America
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
NASTAD
National Alliance on Mental Illness
National Hemophilia Foundation
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Spina Bifida Association
Susan G. Komen
The AIDS Institute