July 28, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9906–P, P.O. Box 8016
Baltimore, MD 21244–8016.

RE: RIN 0938–AU60; CMS-9906-P
Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Dear Administrator Brooks-LaSure:

Community Catalyst appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule - Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond (hereinafter "UPP Rule").

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state and national advocates to leverage and build power so all people can influence decisions that affect their health. It is our belief that health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses and on Capitol Hill.

We support many of the proposals in the UPP Rule which will expand enrollment opportunities, reduce the number of uninsured persons, and restore important Affordable Care Act (ACA) programs and protections.

Provisions of the Updating Payment Parameters and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

A. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability of Coverage (§147.104)

The statutory requirement that a participating issuer must make coverage available to all individuals who apply for it is a core protection for people with preexisting conditions. In 2017, the prior administration announced it would permit issuers to deny coverage to people who the issuer says owe past due premiums. This policy is inconsistent with the statute and was adopted in response to concerns that were asserted but not supported by any evidence. This change presented a clear barrier to coverage for

individuals, some of whom may have regularly paid their premiums, but the issuer failed to properly apply them to the consumer's account. We are therefore pleased that HHS is reassessing this approach and we urge that it be reversed, and full guaranteed availability rights be restored, in the 2023 Payment Notice rulemaking.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Standardized Options (§155.20)

Standardized health plan designs offer numerous advantages to patients and consumers. Requiring plans to adhere to uniform cost-sharing parameters promotes informed decision-making, allowing consumers to draw meaningful comparisons based on variables such as plans' premiums and network composition and design. Standardized plans can be a tool for improving coverage affordability by exempting certain services, such as primary and mental health care, from the deductible. Standard plans can also be designed to reduce health disparities by, for example, lowering cost-sharing for services that treat health conditions that disproportionately affect people of color and others who historically have been underserved.

For these reasons, we support the return of standardized plans on HealthCare.gov in 2023 and urge HHS require – rather than just encourage – participating issuers to offer plans with standardized features. We also suggest HHS consider adopting additional rules that will enhance consumer decision-making, for example, by limiting the number of non-standard designs issuers can offer, and by reinstating the requirement that issuers' offering be meaningfully different from each other. We also recommend HHS consider how best to display standardized plans on HealthCare.gov so that consumers can easily identify them.

2. Navigator Program Standards (§155.210)

We strongly support CMS's decision to re-instate the regulations removed by the previous Administration at *§* 155.210(e)(9), which required Navigators to help individuals with post-enrollment assistance. We firmly believe that robust and comprehensive enrollment assistance does not stop at enrollment. Our experience with assisters on the ground has taught us that helping individuals gain and maintain effective health coverage requires assisting with post-enrollment needs in addition to the application and plan selection process. Most navigators are already conducting post-enrollment activities, so codifying post-enrollment assistance as required responsibility ensures that all people who seek help from a Navigator are accessing the same quality services in post-enrollment support. Reinstating the requirements under §155.210(e)(9) will also help Navigators and CMS with tracking any trends among the issues that arise after enrollment as well as developing solutions to address the issues.

We greatly appreciate that CMS has clarified in the proposed rules that "We are once again not proposing to establish a duty for Navigators to represent a consumer in an appeal, sign an appeal request, or file an appeal on the consumer's behalf." When CMS originally proposed adding §155.210(e)(9), we expressed concerned that some of the original language could be construed as expecting Navigators to be experts in the appeals/complaints processes or held out as the experts in these

areas to their communities. Therefore, we recommend that CMS alter the language of the §155.210(e)(9) to further define what it means by "assistance with" so that Navigators can be clear on the full extent of individual support expected from HHS in these areas. Specifically, if Navigators are expected to assist individuals in ways other than through information and referrals, we request that CMS revise the original language to make explicit these additional forms of assistance. We support CMS's view that these additional requirements are consistent with the view that Congress anticipated individuals would need assistance beyond the application and enrollment process, and that Navigators would maintain relationships with individuals and be a source of such assistance. However, since other community resources are available to provide assistance with these individuals, and particularly because some of these community resources are trained experts (i.e., legal service organizations and tax preparers) we believe Navigators should be required to be aware of these other community resources and know when and how to provide referrals to these resources so that individuals can make an informed decision regarding from whom they would like to receive assistance from.

We further support reinstituting the original language requiring Navigators to provide information and assistance with exemptions because we believe this aligns with Congress's intent to provide individuals with access to skilled assistance with post-enrollment areas. We further support the delineation of the role of Navigators within the exemption filing process to be educating individuals about their rights and responsibilities regarding maintaining minimum essential coverage or filing an application for exemption if needed. Lastly, we support the requirement that Navigators should inform individuals that they cannot provide tax assistance or advice, and that instead, they should be required to provide an appropriate disclaimer regarding the limitation of their services prior to providing assistance. However, we feel that providing individuals with an oral disclaimer that they are not tax advisers and cannot provide tax advice prior to providing any other type of assistance is not the best way to initiate or maintain a strong relationship with an individual and may cause confusion and adversely affect the enrollment relationship. Rather, we suggest that Navigators include disclaimer language within the consent form provided to individuals that authorizes Navigators to provide enrollment assistance and gain access to an individual's personally identifiable information (PII). We believe that including the disclaimer language in the authorization form will allow individuals to be fully informed of the scope of Navigator duties while also allowing Navigators to begin enrollment appointments in their traditional manner and effectively build and maintain relationships with individuals during the appointments.

We also support the requirement that Navigators provide information regarding the tax credit reconciliation process but request further support from CMS in helping Navigators provide the level and type of assistance that is being required of them in the proposed rule. We understand and agree with CMS that Navigators have expertise related to Exchange eligibility and enrollment rules that uniquely qualify them to help individuals with the reconciliation process. However, we are also aware of the resource limitations that Navigators and their funding agencies may face and are concerned about the amount of time that may be required for Navigators to familiarize themselves with all of the IRS resources available, as well as all of the tax law, legal aid, and VITA agencies that may be available in their area. To better help Navigators meet this new requirement, we suggest that CMS incorporate new modules regarding tax credit reconciliation and referrals to tax preparation services into the annual assister training and require both new and returning Navigators to complete the modules, so that Navigators can be provided with a pre-dedicated, mandatory time in which they can build the level of knowledge needed to assist individuals. Similarly, with respect to the original language at 45 CFR 155.210(e)(9)(v), we request that CMS provide Navigators with additional training or information from

IRS on the availability of Volunteer Income Tax Assistance or Tax Counseling for the Elderly Programs so that they can know where and how to make appropriate referrals.

We strongly applaud CMS for codifying assistance with health insurance literacy needs as a formal requirement for Navigators. Our experience on the ground has taught us that individuals often return to assisters with questions regarding how to use their coverage to access to care, and formalizing this type of post-enrollment assistance will ensure individuals are able to use and maintain meaningful coverage. We appreciate that CMS offered as an example that assisters could use the *From Coverage to Care* series, but we further request that CMS provide access to additional resources and information Navigators can use that can help increase their ability to assist with health insurance literacy. Before creating additional health insurance literacy topics for Navigators to be required to provide assistance in, we suggest that CMS provide additional information or referrals to resources where assisters can become knowledgeable of health insurance literacy topics. In particular, many of the assisters we work with report that they often contact issuers to obtain information of specific plan benefits, terminology or services. Therefore, we request that CMS require insurers or agents/brokers to provide information to assisters regarding plan benefits and details to increase Navigators' ability to assist with health insurance literacy.

We request that CMS update and republish their current regulations and guidance surrounding the use of personally identifiable information to make clear whether Navigators are permitted to collect, disclose, access, maintain, store and/or use PII to carry out these proposed post-enrollment activities. We understand that CMS recently updated the model Navigator consent forms to allow individuals to authorize Navigators to use PII to follow up with individuals for certain post-enrollment needs. However, our experience working with assisters has informed us that many Navigators still feel hesitant to maintain any PII after an enrollment appointment other than the authorization form, and many do not keep any PII after an enrollment appointment. Therefore, we request that CMS republish the current guidance so that more Navigators can become aware of it, as well as update the current guidance to make explicit that Navigators can keep and use PII to engage in post-enrollment assistance. Based on the language of the proposed requirements in 45 CFR 155.210(e)(9), we feel that using PII will be a critical component to being able to follow up with individuals and carry out these post-enrollment activities. Therefore, we request that HHS update its guidance to further explain whether and how Navigators can use PII for post-enrollment assistance.

Lastly, we strongly urge CMS to invest funding in Consumer Assistance Programs (CAPs) (*see* 45 CFR 155.205) to assist Navigators in meeting these new requirements. Because CAPs have been assisting individuals with health insurance literacy and filing appeals for years, CMS should re-engage with these entities and provide funding to them. We feel that supporting CAPs and fostering a relationship between Navigators and CAPs will best ensure Navigators can meet these new requirements.

Overall, we applaud these proposed requirements because we believe they will help ensure individuals continue to receive enrollment assistance expertise beyond their initial enrollment, which will further help ensure individuals understand their coverage and how to use it effectively. However, we also feel that HHS and IRS should provide additional training, resources and other support to ensure Navigators can sufficiently meet these requirements.

3. Exchange Direct Enrollment Option (§155.221(j))

In our comments to the Notice of Benefit and Payment Parameters for 2022 Proposed Rule (the "2022 NBPP"), we urged HHS not to finalize a policy under which states could, in effect, eliminate their marketplaces and outsource various statutory responsibilities to private entities. As we explained more fully in those comments, the so-called "Exchange Direct Enrollment Option" conflicts with federal law; would allow states to eliminate the only one-stop marketplace for consumers to compare all available plans and obtain unbiased assistance with enrolling in coverage; and increases the risk that consumers would be steered to insurance products that do not provide ACA protections or qualify for premium tax credits. Since we wrote those comments, the rationale for this option has been further weakened with enactment of the American Rescue Plan Act (ARP) and enhanced subsidies for all consumers, regardless of income.

As we also noted in our earlier comments, allowing states to eliminate HealthCare.gov and instead rely exclusively on the Exchange Direct Enrollment Option poses additional threats to health care coverage to historically marginalized populations by making Medicaid less accessible. That's because HealthCare.gov allows applicants to learn whether they are eligible for Medicaid and how to enroll, if eligible. Direct enrollment sites do not. It is also especially harmful for people with substance use disorders and mental health conditions, particularly with the rise in those conditions during the COVID-19 pandemic. Requiring consumers to use sites that also sell sub-par insurance products, including short-term, limited-duration plans puts these consumers at risk of enrolling in plans that don't provide comprehensive coverage, including coverage of mental health and substance use disorders.

For these reasons, we strongly support the proposal to repeal the Exchange Direct Enrollment Option.

4. Open Enrollment Period Extension (§155.410(e))

We strongly support expanding the annual open enrollment period back to a 75-day period, as it has been in previous years. Overall, increasing the annual open enrollment period from 45 to 75 days would allow individuals more opportunities to thoroughly review their coverage options and obtain enrollment assistance. It would also provide enrollment assisters more time to advertise their services and conduct outreach. During the previous 45-day annual open enrollment periods, our enrollment assister partners expressed concern that 45 days was not enough time to assist all of the individuals who wanted their services.

5. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income No Greater Than 150 Percent of the Federal Poverty Level (§155.420(d)(16))

We strongly support providing a monthly special enrollment period to individuals with incomes up to 150 percent FPL who are APTC-eligible as a way to increase access to health coverage for these individuals and families. Offering this SEP on a monthly basis is also an effective form of outreach and education about APTC eligibility. Our enrollment assister network strongly supports this type of SEP because they often work with individuals and families who weren't aware of the OEP and don't otherwise qualify for an SEP. Allowing individuals and families at this income range who are newly-eligible for APTCs to enroll in coverage at any time of year is also helpful in allowing individuals who become over-income for Medicaid but miss their initial 60-day SEP window to enroll in coverage.

A new, year-round SEP for low-income people would reduce the number of uninsured. Some states already provide year-round enrollment to low-income people without any significant signs of adverse selection. In Massachusetts, people with incomes up to 300 percent of poverty (about $36,000 for an individual or $75,000 for a family of four) can generally enroll in marketplace coverage year-round.

Data from 2020 state COVID-related SEPs in Colorado, the District of Columbia, and Massachusetts show that opening enrollment and reducing barriers to SEPs may actually attract younger and subsequently healthier enrollees.

Easing barriers to SEPs has been an important strategy to counter COVID-19. According to CMS, more than 1.5 million people signed up for coverage via HealthCare.gov between February 15 – June 30 under the COVID-19 SEP. We fully expect the final data from the federal to show that adverse selection was not a factor influencing enrollment, particularly those who qualify for $0 premium coverage.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. User Fee Rates for the 2022 Benefit Year (§156.50)

In the UPP Rule, CMS proposes a modest increase to user fees - 2.75 percent for Federally-Facilitated Marketplaces (FFMs). 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. Under the previous administration, CMS slashed user fees and virtually ceased marketing and outreach and slashed funding for Navigators, core marketplace functions funded by user fees.

User fees are essential to operate the Marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. These include enhancing the consumer experience through improvements to the application and HealthCare.gov, as well as addressing other behind-the scenes issues. We believe CMS should increase user fees and make much needed fixes and enhancements to Marketplace enrollment.

2. Essential Health Benefits (§156.115)

We support the proposed revision to explicitly reference the recently amended Mental Health Parity and Addiction Equity Act - section 2726 of the Public Health Services Act. The revised Parity Act requires qualified health plans to conduct and document a comparative analysis of all non-quantitative treatment limitations (NQTLs) to ensure compliance with Parity Act standards. It also requires qualified health plans (QHPs) to submit the analysis to state or federal insurance regulators, if requested. This is an essential protection for people using QHP services for substance use disorders and/or mental illness, since the fallback of a complaint process is not effective in enforcing the Parity Act.

State regulators should review QHPs for Parity Act compliance prospectively so that an enrollee does not purchase a plan that discriminates in the coverage of mental health or substance use disorders benefits. The Parity Act requires state regulators to review a minimum of 20 NQTL analyses annually

for compliance and take action to remedy violations and notify plan members when a plan fails to correct violations.

3. Network Adequacy (§156.230)

We were deeply concerned with the prior administration's decision to eliminate federal network adequacy standards for plans offered through the FFM and to abandon federal oversight of marketplace plan networks. It is critical to restore and strengthen these protections; we are pleased HHS intends to do so for the 2023 plan year and we look forward to commenting more fully on those forthcoming proposals.

As you revisit these issues, we urge increased scrutiny of networks' ability to provide culturally- and linguistically-competent, anti-bias care and care that is fully accessible to persons with disabilities. This means, among other things, a rigorous assessment of whether a network includes sufficient providers with appropriate language proficiencies, and/or provides sufficient access to appropriate language services, to ensure individuals with limited English proficiency can obtain timely care in their preferred language. It also means networks must ensure access to culturally appropriate care that reflects the diversity of enrollees' backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, and LGBTQ+ individuals. Further, to enable consumers to identify the plans and providers likely to meet their needs, all health plans must be required to indicate in their provider directories the languages, other than English, which are spoken by a provider and/or their staff.

We suggest HHS consider what additional data and materials plans must submit to facilitate a meaningful assessment of the adequacy of their networks. For example, plans should be required to report data showing out-of-network claims submitted (as opposed merely to such claims denied, as is currently required) and the types of providers and services involved. This information can help illuminate areas in which a network may not be meeting enrollees' needs.

We urge the administration to require quantitative metrics for adequacy of plan network adequacy for mental health and substance use disorders services that ensure choice of, and swift access to, providers at every level of care including harm reduction, inpatient, outpatient, residential and long-term recovery supports. Delays in access to care can be life-threatening for people with these conditions.

We also urge the administration to require evidence that plan networks provide enrollees with sufficient access to providers of all reproductive health services that are covered, in accordance with federal and state policies, as well as to LGBTQ+-inclusive care. In 52 geographic regions around the country, the sole providers of acute care are facilities operated by religiously-affiliated health systems that do not allow contraceptive services, sterilizations, abortions, infertility treatments or some types of gender-affirming care. Particularly in those regions, it is important that plan networks include access to alternative providers of such care. In other regions, narrow plan networks could also inhibit enrollees' access to all covered services, should the networks not include alternative providers of care.

4. Segregation of Funds for Abortion Services (§156.280)

We strongly support the proposal to completely repeal the 2019 changes to the double billing regulation at 45 C.F.R. § 156.280(e)(2). This regulation was not implemented due to pending litigation and the COVID-19 pandemic. If it had been implemented, it would have required QHP issuers to send a separate

premium bill for abortion services to consumers and instruct consumers to pay a premium for abortion services in a separate transaction.

We opposed this "double billing" regulation because it:

- would have undermined access to abortion, with devastating impact;
- would have caused confusion resulting in gaps in coverage for individuals and reduced access to abortion and health care generally;
- conflicted with Congress' intent to allow abortion coverage in the Affordable Care Act (ACA) exchanges; and
- would have diminished state flexibility, conflicting with current state mandates to cover abortion and placing issuers in those states in a challenging position.

a. The double billing regulation, if implemented, would have impeded access to abortion care with devastating results for individuals and families

Abortion is health care—a common and safe medical intervention, and a legally and constitutionally protected form of medical care in the United States. One out of four women in the United States will have an abortion by the age of 45. For many, coverage for abortion care means the difference between getting the health care they need when they need it and being denied that care. Individuals denied abortions are more likely to experience eclampsia, death, and other serious medical complications, remain in relationships where interpersonal violence is present, and suffer anxiety after being denied an abortion. Delays can result in complete denial of abortion care, which can have long-term, devastating effects on pregnant people and their families' economic future. The cost of an abortion is a catastrophic expenditure for most people in the United States. Restrictions to abortion coverage particularly harm Black, Indigenous, and other People of Color as well as LGTBQ-GNC individuals who disproportionately struggle with poverty. People with disabilities also face barriers to reproductive and sexual health care, including abortion. The double billing rule would have likely denied many individuals access to abortion, and exposed many individuals and families to untenable economic circumstances.

b. The double billing regulation would have caused confusion resulting in coverage gaps for individuals and reduced access to health care generally

The double billing regulation would have created confusion, anxiety, burdens, and costs for consumers buying plans in the marketplaces, impeding access to care overall. The rule would have lessened consumers' ability to make informed decisions about the plans that met their needs. Consumers would have been confused to receive two separate bills from the same plan and may not have understood they needed to send two separate checks or submit two separate online transactions. Some would not have paid both premiums. Consequently, enrollees would have experienced delays in coverage or outright coverage denials. The impact would have been worse for individuals who already face barriers in navigating health insurance, particularly communities of color, Limited English Proficient speakers, immigrants, individuals with low literacy and educational levels, and those living with visual disabilities and/or impairments. Complying with this rule would also have imposed new costs on issuers, states, and State Exchanges, and federally facilitated exchanges. These costs would have been passed on to consumers in the form of higher premiums.

c. The double billing regulation conflicted with Congress' intent in passing §1303 of the ACA

The double billing regulation undermined the intent of the ACA because it would have created onerous administrative burdens for issuers that cover abortions in their QHPs. Although §1303 of the ACA unfairly segregates abortion from other health care coverage and imposes additional burdens on issuers that offer QHPs covering abortion services, Congress intended §1303 to retain availability of abortion coverage, including allowing states to require abortion coverage. During the ACA debates and negotiations, Congress rejected amendments aimed at more stringent restrictions or prohibitions of abortion coverage. Congress ultimately adopted the Nelson Amendment to replace all other proposed amendments, permitting insurers to cover abortions so long as they comply with the provisions of §1303.

We support the proposal to change the section heading of §156.280 to "Segregation of funds for abortion services," because §1303 explicitly required *issuers* to segregate funds and accounts for abortion coverage; it did not pass on that burden to consumers.

d. The double billing regulation would have conflicted with current state mandates on abortion coverage, and placed issuers in those states in an untenable position

Section 1303(c)(1) states that the ACA "does not preempt or have any other effect on state laws regarding the requirement of (or prohibition of), any coverage, funding, or procedural requirements on abortions." Recognizing that reproductive health care is a critical part of a person's wellbeing, some states require abortion coverage in most of their plans, just like any other health service. As a result, most health plans in those states, including QHPs, must cover abortion services.

The double billing regulation plus the regulatory requirements of §1303 would have interfered with states' requirements to offer abortion coverage in their plans. In 2019, HHS threatened to enforce the double billing regulation if states did not follow it, seriously overriding states' authority over issuers that operate in their states. Thus, the double billing regulation would have disrupted the nature of collaboration and partnership that the Affordable Care Act meant to create between the states and the federal government.

Provisions of the Proposed Rule for Section 1332 Waivers—Department of Health and Human Services and Department of the Treasury

A. 31 CFR Part 33 and 45 CFR Part 155—Section 1332 Waivers

1. Section 1332 Application Procedures—Statutory Guardrails (31 CFR 33.108(f)(3)(iv) and 45 CFR 155.1308(f)(3)(iv))

We opposed guidance issued by the prior administration (the "2018 guidance") that reinterpreted the statutory guardrails for Section 1332 waiver applications to impermissibly encourage states to pursue waiver programs that circumvent non-waivable statutory protections and that would potentially put consumers in a position of receiving less affordable and comprehensive coverage. We also firmly opposed the decision to codify these policies in the 2022 NBPP.

For these reasons, we strongly support the proposal to rescind the guardrail interpretations announced in the 2018 guidance and codified by the 2022 NBPP. We also support the policies and interpretations described in the preamble to the Improving Health Insurance Markets Proposed Rule, including the Departments' recommitment to ensuring that waivers must not adversely affect vulnerable and underserved residents.

We also ask the Departments to revisit the "deficit neutrality" guardrail for 1332 waivers, which requires states to demonstrate that proposed waiver programs do not increase the federal deficit. An overly narrow interpretation of this requirement has prevented states from pursuing innovative new models that would expand coverage, which is inconsistent with the original intent of this waiver program and the Administration's goal of increasing enrollment in comprehensive coverage. It is also inconsistent with the other guardrails in the statute and the ACA more broadly

We recommend that the administration reinterpret this provision to use full enrollment as the "baseline" for estimating the impact on the federal budget and assessing "deficit neutrality." This alternate interpretation of "deficit neutrality" aligns with the aims of the ACA to expand coverage and would grant states the flexibility to create new waiver designs, including a state-level public option, to meet those goals.

2. Modification From the Normal Public Notice Requirements (31 CFR 33.118, 31 CFR 33.120, 45 CFR 155.1318, and 45 CFR 155.1320)

In November 2020, the Departments weakened public notice requirements for Section 1332 waivers during the COVID-19 public health emergency (PHE) because existing requirements to obtain public input on waiver proposals "may impose barriers for states pursuing a proposed waiver request during the PHE." The guidance would permit a state to delay its public notice and comment period until after it has already submitted its application to the Departments; delay the federal comment period; and reduce the length of these comment windows. We oppose the proposal to extend this flexibility beyond the COVID-19 PHE to other "emergent" situations, broadly defined.

We appreciate that the Departments seek to provide flexibility to states to respond to urgent events, but we believe that the revised public notice requirements risk unintended negative consequences for consumers. By law, Section 1332 waiver applications must receive the benefit of public notice and comment at the state and federal levels, and these processes must be sufficient to "ensure a meaningful level of public input." Stakeholders, including the state advocates with whom we work, rely on these public comment periods to provide feedback on how waiver proposals will impact consumers and other key stakeholders. We believe a rule that allows states to cut short the notice and comment periods and to delay these essential processes until after governmental decisions on the waiver have already been made, does not allow for a meaningful level of public input.

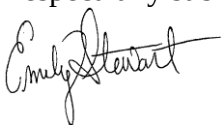
Rules that would make it easier to bypass statutory obligations to involve the public in the waiver application process raise the risk that a waiver proposal likely to adversely affect consumers could be rushed to approval without adequate consideration. We urge the Departments not to finalize these proposals.

Additional comment: Addressing DACA Eligibility

While not raised in the Notice of Proposed Rulemaking, we urge CMS to repeal the provision at §152.2(8) that excludes recipients of Deferred Action for Childhood Arrivals (DACA) from the definition of lawfully present for the purposes of eligibility for marketplace coverage. This decision arbitrarily excludes DACA recipients from access to health coverage for no principled reason. Particularly in the context of the pandemic, where lack of access to health insurance can be deadly or increase the likelihood of bankrupting medical bills, it is important to ensure that everyone has access to coverage. DACA recipients pay over $5 billion in federal taxes annually yet are excluded from buying even unsubsidized on-exchange coverage. Two in five people eligible for DACA are uninsured. If they were granted access to exchange coverage, they would likely improve the health insurance risk pools, bringing costs down for everyone, because many are young and nearly 70% are in excellent or very good health.

Thank you for the opportunity to submit these above recommendations. Please do not hesitate to contact Eva Marie Stahl, Director of Policy and Partnerships at emstahl@communitycatalyst.org if you have any questions or if you would like additional information.

Respectfully submitted,



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