

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

Dear Administrator Brooks-LaSure:

Howard Brown Health is the largest LGBTQ health center in the Midwest, serving more than 38,000 patients across twelve clinic locations in Chicago. It is through our many programs—including primary care, behavioral health, mental health services, HIV/STI prevention, elder services and community outreach initiatives—that Howard Brown fulfills its mission of eliminating health disparities and improving health outcomes experienced by LGBTQ individuals and residents of the Chicago area and beyond. As a Federally Qualified Health Center (FQHC), Howard Brown provides comprehensive, high quality and affordable care to all patients, regardless of ability to pay or insurance coverage.

Howard Brown appreciates the opportunity to comment on the CMS proposed rule - Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond (hereinafter “UPP Rule”). We support many of the proposals in the UPP Rule, which will expand enrollment opportunities and increase access to insurance coverage, particularly for low-income people and other marginalized communities that we serve.

We strongly support the proposal to establish a new Special Enrollment Period (SEP) specifically for individuals and dependents who are eligible for advance premium tax credits (APTCs) and whose household income is under 150% of the federal poverty level (FPL). This low-income SEP would allow eligible low-income individuals to enroll at any time during the year. There are several SEPs that already exist to help people prevent short- and long-term gaps in insurance coverage. However, analysis by the Urban Institute found that of the more than 10 million uninsured people who could obtain coverage through SEPs, fewer than 15% of those who qualify are actually enrolled in SEPs.¹ One

¹ <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>

barrier preventing uninsured people from enrolling in SEPs is the generally brief SEP enrollment windows to gain coverage. The new proposed SEP for low-income people allows enrollment at any point during the year, reducing barriers for qualified individuals to gain access to insurance.

Some states already provide year-round enrollment to low-income people. For example, in Massachusetts, people with incomes up to 300% FPL (about \$36,000 for an individual or \$75,000 for a family of four) can generally enroll in marketplace coverage at any point during the year.² These successful state models have shown that year-round SEPs can increase insurance coverage and ease logistical challenges—such as burdensome documentation and complex deadlines—that prevent eligible individuals from enrolling in other SEPs. This is especially important for low-income people, who are often already overburdened with juggling competing priorities and meeting immediate needs for survival.

CMS also notes that it is reconsidering its interpretation that persons who owe past due premiums are prohibited from enrolling in coverage until they satisfy arrearages. We strongly support revising this provision. The ACA is clear – an issuer “must accept every employer and individual in the State that applies for such coverage” (42 U.S.C. 300g-1). This policy has created significant hardship for low-income individuals trying to access insurance.

These changes are especially important for expanding access to insurance for LGBTQ people and other marginalized communities. Recent research from the Williams Institute shows that 21.6% of LGBTQ people live in poverty compared to 15.7% of cisgender, straight people. The poverty rates were especially high among transgender people (29.4%) and bisexual women (29.4%).³ Research has also shown that LGBTQ people, especially Black and Latinx LGBTQ people, experienced higher rates of job loss, serious financial problems, and issues accessing healthcare during the pandemic.⁴ These changes to help expand access to health insurance for low-income individuals will particularly benefit LGBTQ people and other marginalized communities who have been hardest hit by the pandemic.

We also support several other strategies included in this proposed rule that will help to improve access to health insurance including:

² <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>

³ <https://williamsinstitute.law.ucla.edu/publications/lgbt-poverty-us/>

⁴ <https://www.lgbtmap.org/release-2020-covid-impact-lgbtq-households>

- Reinstating requirements for navigators to assist consumers with a variety of overwhelming and complex activities, such as: filing appeals on eligibility determinations, understanding basic concepts and rights associated with health coverage, applying for exemptions, helping consumers reconcile ATPCs, and finding assistance for tax filing. As a community health center, we also understand the benefit of having a trusted community partner engaged in these navigation services. We urge CMS to reconsider restoring requirements that at least one navigator organization in each state should be a trusted community nonprofit.
- Repealing a provision that allows for “direct enrollment” exchanges, which lack consumer protections and have been found to be non-compliant with ACA protections.⁵
- Extending the annual open enrollment period to January 15. Applying for health insurance can have significant impact on someone’s finances and health. For many consumers, buying health insurance is one of the most complicated, and consequential, financial decisions they make. Requiring people to make these important and complicated decisions in just a few weeks during the holiday season makes it more difficult to get the best coverage. CMS could follow the lead of California and New Jersey and extend the open enrollment deadline out even further, to January 31.
- Strengthening insurance network adequacy oversight. CMS should review out-of-network utilization rates, reimbursement rates, denial rates, prior authorization requirements and other related parameters to assess network adequacy. Research has shown that out-of-network utilization rates are particularly high for mental health and substance use disorder treatment,⁶ limiting access to these services even further, particularly for low-income people. Additionally, reviews should include whether the provider network is sufficient to deliver culturally competent, anti-bias care, and with providers fully accessible to persons with disabilities. This should include capacity to delivery LGBTQ-affirming care. One enforcement tool would be to review the number of out-of-network claims denials and assess plans with high numbers of out-of-network denials for their size. High rates of denials should prompt further review. Further, states and CMS should conduct some direct tests of provider availability, discussed in the 2014 HHS Office of the Inspector General Report highlighting the importance direct testing of Medicaid provider networks.

⁵ https://www.lls.org/sites/default/files/National/undercovered_report.pdf

⁶

https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf



Thank you for the opportunity to comment on this important issue. If you have further questions, please contact Tim Wang, Director of Policy and Advocacy, at timothyw@howardbrown.org.

Sincerely,

David Ernesto Munar, President and CEO
Howard Brown Health