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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted Electronically

RE: RIN 0938-AU97; CMS-2022-0192
Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

The National Women's Law Center ("the Law Center") appreciates the opportunity to comment on the Notice of Benefit and Payment Parameters for 2024.[1] Since 1972, the Law Center has fought for gender justice in the courts, in public policy, and in our society. It has worked to protect and advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and intersecting forms of discrimination. Through our work to develop and implement the Affordable Care Act, we have seen the impact it has had on women's health and access to care, and we firmly believe that robust enforcement of its provisions will continue to improve their lives.

We support many aspects of the rule and offer suggestions to strengthen it. Among other recommendations, we urge the Department of Health and Human Services ("the Department") to adopt the following policies:

- Prohibit denials of Advance Premium Tax Credits (APTC) based on failure to file and reconcile;
- Extend the timeline for resolving income inconsistencies and use self-attested income when IRS data is unavailable;
- Adopt the proposed limits on non-standardized plans; and

[1] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 78206 (proposed Dec. 21, 2022) (to be codified at 45 C.F.R. pts. 153, 155, and 156) (hereinafter "Proposed Rule").

- Establish new Essential Community Provider (ECP) categories for mental health and substance use disorder services and require issuers to meet the 35% threshold within every ECP category.

I. Resolving Financial Discrepancies

a. Failure to File and Reconcile (§ 155.305)

The Department proposes to change the rules for denying APTC for failure to file and reconcile (FTR). Instead of denying APTC after one year of FTR, under the proposed policy Exchanges may withhold APTC only when the IRS reports that the taxpayer has failed to reconcile for two consecutive years. We appreciate the Department's commitment to improving this policy, but we believe its proposal does not sufficiently mitigate the risks of unwarranted denials of APTC. We urge the Department instead to remove this penalty entirely.

This penalty has led many consumers to lose their APTC despite their continued eligibility. As the Department recognizes, many enrollees do not understand the requirement to reconcile their APTC; indeed, even third-party tax preparers are often unaware of the requirement and do not prompt consumers to include the requisite IRS form.[2] Simply providing consumers with a notice that they must reconcile their APTC is often insufficient. Many consumers may find notices regarding their tax responsibilities difficult to understand or navigate, sometimes due to barriers related to language, literacy, or disability. Some might not even receive the notice or receive it too late, particularly if they are experiencing housing changes or instability or, in the case of online notices, if they face challenges to accessing electronic communications. Even consumers who are aware of their responsibilities might find that unintended errors in this potentially complex filing puts them in FTR status.

The resulting consequences for consumers can be severe. As the Department recognizes, "enrollees who lose APTC tend to end their Exchange coverage and will experience coverage gaps, as they cannot afford unsubsidized coverage."[3] Specifically, the Department's data indicates that loss of APTC due to FTR has a "significant impact…on whether enrollees continue to remain in coverage offered through the Exchange."[4] Denial of APTC therefore "effectively means many consumers may lose access to medical care."[5]

We recognize that the Department is attempting to balance consumers' welfare with the possibility of fraud. But whereas the evidence of widespread APTC fraud is limited and attenuated, the impact of losing insurance as a result of improper APTC termination is well substantiated. Numerous studies have demonstrated that uninsured individuals are less likely to

[2] *Id*. at 78256.
[3] *Id*.
[4] *Id*. at 78257.
[5] *Id*. at 78256.

receive preventive care and access services for major health conditions and chronic diseases.[6] Uninsured women—disproportionately Black, Latina, and Native women—get less adequate and lower quality care and are less likely to receive services like mammograms, Pap tests, and blood pressure checks.[7] As a result, uninsured women are more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality (especially among Black women)[8] to later-stage cancer diagnoses.[9]

In addition to creating the risk that eligible consumers will be denied APTC, this penalty continues to be impractical to implement. The operational difficulties it presents will likely persist even if the policy is changed to terminate APTC only after two consecutive years of FTR. Exchanges still will be unable to share federal tax information with consumers who are not the household tax filers, meaning that the notices they issue may not explicitly identify FTR as the reason for terminating APTC. In its 2019 Notice of Benefits and Payment Parameters rule, the Department recognized that the workaround of listing FTR among several other possible reasons for termination resulted in only 60% of households taking appropriate remedial action upon receiving the notice. While the Department at the time suggested that this was because the remaining 40% were ineligible, it is more likely that this rate indicates that the notice consumers received was insufficient.

We are further concerned that unfair APTC denials can occur if there are IRS processing delays in the second year after a consumer's initial FTR status. The Department has recognized the impact of the ongoing IRS backlog and has rightly paused the enforcement of FTR penalties as a result, but IRS delays in providing Exchanges with up-to-date tax information may still arise in the future, impacting eligible consumers' receipt of APTC. If the Department does adopt the proposed two-year policy, we encourage it to provide for an automatic pause on FTR updates if there is another IRS backlog, as well as to postpone implementation until the IRS can update its information systems.

Finally, we stress that this penalty is unnecessary and not required by any statute. We believe that existing IRS penalties for failing to file a proper tax return are sufficient for dealing with FTR, and that the harms of an eligible consumer improperly losing APTC far outweigh any deterrent value the policy may have.

b. Extending Timeline for Resolving DMIs (§ 155.315)

The Department proposes to extend the timeline for consumers to resolve a data matching issue (DMI) when there is an inconsistency between self-attested income and IRS data, allowing for an automatic extension of 60 days. We support this provision. The current policy places the burden

[6] Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.
[7] Kaiser Family Foundation, *Women's Health Insurance Coverage* (Dec. 21, 2022), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage.
[8] Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health* (Jul. 26, 2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.
[9] Gerard A. Silvestri et al., *Cancer Outcomes Among Medicare Beneficiaries and Their Younger Uninsured Counterparts*, HEALTH AFFAIRS (May 2021), https://doi.org/10.1377/hlthaff.2020.01839.

on the consumer to obtain an extension, an option of which many are not aware. It also creates uncertainty for consumers by leaving Exchanges with broad discretion to decide whether to grant the extension.

As the Department observes, DMIs have a disproportionate impact on households with low incomes. Most households with income DMIs have low incomes, and those with an attested household income below $25,000 are 25% less likely to successfully submit verifying documentation.[10] DMIs may particularly affect households led by single mothers, who are far more likely to have low incomes than other household compositions—particularly households led by Native, Black, and Latina mothers.[11]

For many consumers, 90 days is an insufficient length of time to resolve a DMI. This is particularly true when the process for documenting household income is more complicated, as is often the case for consumers who have multiple or fluctuating sources of employment. Such consumers are more likely to be women, people of color, and people with low incomes—all of whom are more likely to work multiple jobs[12] and have precarious employment.[13] Extending the period for resolving a DMI may help reduce the disparities in coverage that these groups already face.

c. Use of Self-Attested Income When IRS Data is Unavailable (§ 155.320)

The Department proposes that Exchanges rely on self-attested income when IRS data is not available, such as when an applicant was not required to file a tax return. We support this provision. The current policy of creating a DMI in such cases burdens enrollees, who must provide supporting documentation to resolve the DMI or else be determined ineligible for APTC or cost-sharing reduction (CSR). As noted, because many people eligible for APTC cannot afford to pay for unsubsidized insurance, loss of APTC can amount to a denial of coverage. Due to high rates of poverty, single mothers, women of color, disabled women, and women overall are more likely fall under the tax filing threshold[14] and thus be disadvantaged by the current policy. The proposed change would help them stay connected to coverage—an outcome especially important given the health disparities they already face.

[10] Proposed Rule at 78258.
[11] Jessica Semega & Melissa Kollar, *Income in the United States: 2021* (Sep. 2022), https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-276.pdf.
[12] Keith A. Bailey & James R. Spletzer, *A New Way to Measure How Many Americans Work More Than One Job* (Feb. 3, 2021), https://www.census.gov/library/stories/2021/02/new-way-to-measure-how-many-americans-work-more-than-one-job.html.
[13] *See* Vanessa M. Oddo et al., *Changes in Precarious Employment in the United States: A Longitudinal Analysis*, 47 SCANDINAVIAN JOURNAL OF WORK, ENVIRONMENT & HEALTH 171 (Dec. 7, 2020), www.doi.org/10.5271/sjweh.3939.
[14] John Creamer et al., *Poverty in the United States: 2021* (Sep. 2022), https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-277.pdf.

II. Improving Coverage Quality

a. Limits on Non-Standardized Plans (§ 156.202)

We support the proposal to limit the number of non-standardized plans to two per product network and metal level for each service area. The number of non-standardized plans has ballooned well past the point that it is productive or meaningful for consumers. As the Department notes, the weighted average number of non-standardized plans available to each consumer was 107.8 in PY 2022.[15] The resulting choice overload makes it harder for many consumers to select the plan that best aligns with their needs and deters some from choosing a plan at all.[16] Conversely, limits on non-standardized plans in various states have been shown to result in more beneficial coverage and higher satisfaction for consumers.[17]

Studies suggest that women, as well as older adults, people with chronic health conditions, and people with low incomes, are particularly harmed by choice overload in health insurance. When presented with a large number of options, these groups may be more likely to make enrollment decisions that result in higher costs than optimal.[18] And as the Department notes, the large number of near-duplicate plans in the silver metal level places on an inequitable burden on consumers with low-incomes, who "face the greatest challenges in selecting the most suitable plan" yet "can least withstand the consequences of choosing a plan that costs too much and delivers too little."[19] Additionally, as variations in non-standardized plans often cannot be identified without a detailed analysis of benefit designs, they may create particular barriers for people who already have constrained resources for navigating insurance—such as people with limited English proficiency,[20] low incomes, complex health needs, or inadequate internet access.[21]

Limiting non-standardized plans will help many consumers navigate plan options, building on previous measures that the Department has taken to this end, like requiring the inclusion and differential display of standardized plans. We note that an excessive number of non-standardized plans can exacerbate these barriers even when the distinction between them is significant. While the Department's alternative proposal of applying a meaningful difference standard would help reduce the number of similar plans, it could still leave many consumers with an unwieldy range

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[15] Proposed Rule at 78280.
[16] *See* Rose C. Chu et al., *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 3 (Dec. 28, 2021), https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.
[17] *E.g., id*. at 12.
[18] *Id*. at 4; Saurabh Bhargava et al., *Do Individuals Make Sensible Health Insurance Decisions? Evidence From a Menu With Dominated Options* 3 (May 2015), https://www.nber.org/system/files/working_papers/w21160/w21160.pdf.
[19] Proposed Rule at 78281.
[20] Tianyi Lu & Rebecca Myerson, *Disparities in Health Insurance Coverage and Access to Care by English Language Proficiency in the USA*, 2006–2016, 35 J. General Internal Medicine 1490 (2020), https://doi.org/10.1007/s11606-019-05609-z.
[21] *See, e.g.,* Krutika Amin et al., *How Might Internet Connectivity Affect Health Care Access?* (2020), https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access.

of options. Therefore, we recommend that the Department limit the number of non-standardized plans rather than apply a meaningful difference standard.

b. Network Adequacy (§§ 156.230, 156.235)

We support maintaining the requirement for essential community provider (ECP) participation standards at 35%. ECPs, which serve predominantly low-income, medically underserved communities, provide vital care for women, people of color, LGBTQI+ people, and disabled people. For example, many women rely on ECPs like family planning clinics for sexual and reproductive health, preventive health screenings, and other care. And Ryan White clinics are critical for people living with HIV, who are disproportionately LGBTQI+ people and people of color, and who have historically faced stigma and discrimination in other health care settings.

We also support creating new standalone categories for mental health and substance use disorder treatment. These requirements can help reduce some of the barriers that women overall and women of color in particular face to these services.[22] Additionally, we support setting in-category thresholds for FQHCs and family planning providers, but we urge the Department to require QHPs to meet the 35% threshold within *all* categories of ECPs. This helps ensure that enrollees have adequate access to all important types of ECPs, including those that serve people with specific health needs, like Ryan White providers.

III. Navigators and Other Assisters (§§ 155.210, 155.215)

We support lifting the prohibition on Navigators and other Assisters providing door-to-door or unsolicited enrollment assistance. As a result of this prohibition, consumers must initiate contact or make appointments, putting the burden on them to identify their coverage options and the available Navigators and Assisters. This burden particularly disadvantages those who have limited access to travel because of low income, lack of transportation, immunocompromised status, or mobility, sensory, and other disabilities. Given the measures that the Department has already taken to protect consumer privacy and security, this proposal strikes an appropriate balance between mitigating those concerns and expanding access to Navigators and Assisters.

IV. New Payment HCC for Gender Dysphoria (§ 153.320)

The Department requests input regarding the addition of a new payment HCC for gender dysphoria. We appreciate the Department's commitment to improving access to gender-affirming care and accurately capturing its utilization in risk adjustment models. To that end, we believe that it is not necessary or appropriate at this time to add a payment HCC for gender dysphoria. We note that even with growing access to gender affirming care, the budgetary impact of impact of utilization remains negligible.[23]

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[22] *See, e.g.,* Miguel Pinedo et al., *Women's Barriers to Specialty Substance Abuse Treatment: A Qualitative Exploration of Racial/Ethnic Differences*, 22 JOURNAL OF IMMIGRANT AND MINORITY HEALTH 653 (Aug. 1, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7075735.

[23] Kellan Baker & Arjee Restar, *Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population*, 50 JOURNAL OF LAW, MEDICINE & ETHICS 456 (Nov. 18, 2022), www.doi.org/10.1017/jme.2022.87.

V. Special Enrollment Periods After Loss of Medicaid Coverage (§ 155.420)

We support giving Exchanges the option to extend the enrollment window following loss of Medicaid coverage from 60 days to 90 days. This option will be especially important as the continuous coverage requirement unwinds. Even before the pandemic, consumers who lost Medicaid coverage faced challenges in transitioning to Marketplace coverage. A new study of 2016–2019 data, for example, found that nearly two-thirds (65%) had a period of uninsurance following disenrollment from Medicaid or CHIP.[24] These problems will likely be exacerbated during the anticipated large-scale disenrollment in the coming months, particularly as many agencies have outdated contact information or may experience delays transferring Medicaid account information to Exchanges. These problems will have a disproportionate impact on Black and Latine people, who make up more than half of Medicaid and CHIP enrollees.[25] It will also have an outsized impact on women[26] and disabled people,[27] who are more likely to be enrolled in Medicaid.

Because the continuous coverage requirement is set to unwind in 2023, we encourage CMS to separately instruct Exchanges that they can already extend the special enrollment window under existing authorities, rather than wait for specific authorization for PY 2024.

VI. Conclusion

We appreciate the opportunity to comment on this proposed rule. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further information, please contact Ma'ayan Anafi, Senior Counsel for Health Equity and Justice at the National Women's Law Center, at manafi@nwlc.org.

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[24] Bradley Corallo et al., *What Happens After People Lose Medicaid Coverage?* (Jan. 25, 2023), https://www.kff.org/medicaid/issue-brief/what-happens-after-people-lose-medicaid-coverage.

[25] *See* Patricia Boozang & Adam Striar, *The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage* (Sep. 17, 2021), https://www.shvs.org/the-end-of-the-covid-public-health-emergency-potential-health-equity-implications-of-ending-medicaid-continuous-coverage.

[26] Rachel West & Katherine Gallagher Robbins, *Who Receives Medicaid? A State-by-State Breakdown* (Jul. 20, 2017), https://www.americanprogress.org/article/receives-medicaid-state-state-breakdown.

[27] MaryBeth Musumeci & Kendal Orgera, *People with Disabilities Are at Risk of Losing Medicaid Coverage Without the ACA Expansion* (Nov. 2, 2020), https://www.kff.org/medicaid/issue-brief/people-with-disabilities-are-at-risk-of-losing-medicaid-coverage-without-the-aca-expansion.