**NY State of Health**
**Comments on HHS Notice of Benefit and Payment Parameters for 2022**

NY State of Health, the State's Official Health Plan Marketplace submits the following comments on the proposed regulations for 31 Part 33 and 45 CFR Parts 147, 155, and 156; Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule [CMS-9906-P].

## III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2022

D. Part 155 - Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

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

- Proposed Rule
  Part 1 of the 2022 Payment Notice final rule (codified § 155.221(j)), established a process for states to elect a new Exchange Direct Enrollment (Exchange DE option) to work with private sector entities to operate enrollment websites.

  The proposed rule would repeal the Exchange DE option and corresponding user fee that were to be implemented under Part 1 of the NBPP.

- NY State of Health Comments
  NY State of Health supports the Proposed Rule's repeal of the Exchange DE option, which would permit private-sector entities to assist consumers in enrolling in QHPs. As we have stated previously in comments to the Proposed Rule, when individual consumers apply for coverage, they often do not know whether they are eligible for insurance affordability programs or QHPs, particularly if their employment situation or their household composition has changed. Direct enrollment entities would complicate and could hinder the ability of consumers to determine whether they are eligible for programs such as Medicaid or the Children's Health Insurance Program (called Child Health Plus in New York). In addition, Direct enrollment entities create unnecessary consumer confusion regarding the platform for applying for health insurance with financial assistance available, and increases consumer susceptibility to fraudulent actors.

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

- Proposed Rule
  The proposed rule seeks to amend paragraph (e) of § 155.410 to extend the dates of the annual open enrollment period for the 2022 coverage year and beyond to November 1st through January 15th of the applicable benefit year. It is anticipated that if the January 15th end date is finalized, it would apply to all exchanges, including state exchanges for the 2022 coverage year and beyond.

- NY State of Health Comments
  NY State of Health supports HHS' extension of the annual open enrollment period and also encourages HHS to give state-based Marketplaces the flexibility to set their own open enrollment periods. NY State of Health believes the Healthcare.gov open enrollment period could represent the minimum length permitted while states can choose to extend it further.

## E. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

### 3. Segregation of Funds for Abortion Services (§156.280)

- Proposed Rule
  The proposed rule seeks to repeal the separate billing regulation at §156.280(e)(2)(ii) and amend the regulatory text to codify the previous policy in the 2016 Payment Notice, providing issuers flexibility in selecting a method for complying with the separate payment requirement in Section 1303 of the ACA.

- NY State of Health Comments
  NY State of Health strongly supports the proposal to rescind the separate billing regulation at §156.280(e)(2)(ii) and amend the regulatory text to codify the prior guidance adopted in the preamble of the 2016 Payment Notice for complying with Section 1303. As we stated in response to the Program Integrity Rule, this policy would have caused unnecessary consumer confusion and may have even led to coverage losses.

  Further, the separate billing regulation provided no evidence of noncompliance with section 1303(b)(2) of the Affordable Care Act [Prohibition on the Use of Federal Funds], yet contained onerous new billing requirements (45 C.F.R. §156.280) that would have resulted in increased costs to health plans to issue an estimated additional 1.9 million bills per year and to NY State of Health as a result of increased Customer Service call volume estimated to cost additional $600,000 per year.

## IV. Provisions of the Proposed Rule for State Innovation Waivers – Department of Health and Human Services and Department of the Treasury

## A. 31 CFR Part 33 and 45 CFR Part 155 – State Innovation Waivers

1. Section 1332 Application Procedures (31 CFR 33.108 and 45 CFR 155.1308), Monitoring and Compliance (31 CFR 33.120 and 45 CFR 155.1320), and Periodic Evaluation Requirements (31 CFR 33.128 and 45 CFR 155.1328)

- Proposed Rule
  The January 2021 rule issued by CMS adopted wholesale the 2018 guidance issued by the Trump administration, which limited the application of the statutory guardrails that apply to States' requests to waive affordability and availability requirements. CMS now proposes to rescind the 2018 guidance, and to not adopt any of the 2018 guidance into regulation. CMS proposes to instead reference back to the 2015 guidance, which provided for more stringent application of the statutory guardrails.

- NY State of Health Comments
  NY State of Health supports the return to the affordability, comprehensiveness, and coverage guardrails outlined in the 2015 1332 waiver guidance, which provided greater consumer protection by avoiding the risk of non-ACA compliant plans drawing enrollees and risk from the more comprehensive plans.

  Regarding the federal guidance on deficit neutrality, the 2015 1332 waiver guidance penalizes any policy that makes coverage more affordable for lower income populations currently eligible for APTC. This means that if a state proposes a 1332 waiver which reduces monthly premiums and cost-sharing—well documented barriers to health insurance take-up on the individual market— with the objective and expectation of increasing enrollment, the federal pass-through funding methodology would require the state to bear the costs of additional enrollees who were eligible but not enrolled prior to the waiver. In effect, this pass-through methodology penalizes states seeking to innovate through a 1332 waiver since, outside the 1332 process, the federal government bears the costs when those eligible but not yet enrolled decide to enroll.

  As such, NY State of Health recommends revisions to the 1332 federal deficit neutrality guidance to consider changes to:
  - Take into account those who are currently eligible for coverage, but unenrolled, in the baseline coverage and costs used to compute pass-through funding; OR
  - Compute pass-through funding on a per capita basis, which provides a sustainable funding source in the event future enrollment exceeds current levels.