The Enrollment Coalition

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

RE: CMS-9899-P, HHS Notice of Benefit and Payment Parameters for 2024 Proposed Rule

On behalf of The Enrollment Coalition, the following comments are in response to the HHS Notice of Benefit and Payment Parameters for 2024. We appreciate the opportunity to respond to this proposed rule.

The Enrollment Coalition is a group of organizations across the health care community, including consumer advocates, patient advocates, health plans, health care providers, employers, and technology and data organizations. Our mission is to collaboratively identify, develop, and advance actionable policy recommendations for federal policymakers aimed at improving enrollment data, systems, and processes to foster the enrollment of uninsured Americans under age 65 into existing health coverage plans and programs for which they are otherwise eligible.

Overall, the Enrollment Coalition appreciates that HHS is considering ways in the Notice of Benefit and Payment Parameters for 2024 to remove existing barriers and facilitate transitions of coverage. We look forward to working with the Administration to continue to advance these shared goals.

Navigators:

HHS proposes repealing provisions that currently prohibit Navigators, certified application counselors, non-Navigator assistance personnel in Federally-facilitated Exchanges (FFEs), and other assistance personnel in State-Based Exchanges (SBEs) from using unsolicited means of direct contact (i.e., door-to-door visits) to help consumers fill out applications or enroll in health coverage. Repealing these restrictions would enable assisters to reach a broader consumer base in a timely manner, thereby helping to reduce uninsured rates and health disparities by removing underlying barriers to accessing health coverage. The Enrollment Coalition supports removing these barriers to accessing health coverage through assisters.

Transitions of Coverage:

CMS proposes a change to smooth transition between different types of health coverage. CMS proposes alterations to the current coverage effective date requirements that would allow Exchanges to offer earlier coverage effective start dates for people losing Medicaid or CHIP

coverage. The Enrollment Coalition supports the proposal to ease transitions of coverage and prevent coverage gaps.

Special Enrollment Period for Individuals Losing Medicaid/CHIP Coverage:

CMS proposes a modified Special Enrollment Period (SEP) for individuals losing Medicaid or CHIP coverage. CMS proposes that for consumers eligible for an Advanced Premium Tax Credit due to loss of Medicaid or CHIP coverage, the Exchange will have a new special rule option providing them with 90 days after the initial loss of Medicaid or CHIP coverage to select an Exchange plan for coverage.

The Medicaid and CHIP Payment and Access Commission (MACPAC) released an issue brief in July 2022 on Transitions Between Medicaid, CHIP, and Exchange Coverage. The report, which summarizes MACPAC's analysis of insurance affordability program enrollment data and beneficiary transitions among those programs in 2018 found that only about 3 percent of all adult and child beneficiaries who were disenrolled from Medicaid and CHIP enrolled in exchange coverage within a year after disenrolling, and most individuals who moved from Medicaid to the exchange had a gap in coverage and these gaps were longer for racial and ethnic minorities.[1]

The Enrollment Coalition strongly supports facilitating smoother transitions to coverage for individuals at risk of losing Medicaid or CHIP coverage and we appreciate that CMS has proposed changes to address this issue. Additional clarification from CMS regarding the process for the proposed SEP, such as when issuers could expect to receive updated re-enrollment data from CMS to incorporate into rate renewal letters, will be critical to this proposal.

Autoenrollment Policies:

HHS noted it is seeking comment on "all auto-enrollment policies that could better ensure consumer's continuous access to health coverage, including policies that may require additional grants of authority from Congress to HHS." The Enrollment Coalition believes that it must be a top policy priority to ensure that those who are eligible are enrolled and retained in coverage. Autoenrollment policies can bridge the persistent enrollment gap and promote equity and health for those needing care, and we appreciate that CMS is considering autoenrollment policies. The Coalition has developed a framework and set of principles for an autoenrollment policy that supports the enrollment of eligible individuals and families, protects patient choice, and preserves program integrity. The framework and principles are described below:
Enrollee Protections: Autoenrollment policies should protect enrollees and respect affirmative choices they have made. These protections include:

- Avoiding disruption to existing care relationships, which can lead to delayed care and worse health outcomes;

[1]MACPAC Issue Brief: Transitions Between Medicaid, CHIP, and Exchange Coverage, July 22, https://www.macpac.gov/wp-content/uploads/2022/07/Coverage-transitions-issue-brief.pdf.

- Helping enrollees understand their potential out-of-pocket costs, coverage, and appropriate contacts for common needs and questions;
- Maintaining affirmative consumer choices, including primary care provider selection, until or unless changed by the consumer and not overriding consumer choices with automatic assignments;
- Communicating with enrollees effectively, employing a series of notifications using multiple forms of communication (mail, email, phone call, text message) about opportunities to select and review plans; adequate time for the enrollee to review autoenrollment selection and opt out; and an appeals process; and
- Ensuring adequate network capacity for enrollees.

Fair treatment of health plans: Autoenrollment policies should take care to avoid inadvertent disruption to or penalization of participating health plans, including:

- Holding health plans harmless from enrollee concerns that are not the fault of the plan, such as which plan the enrollee is assigned to; and
- Ensuring fairness to participating plans when assigning members.

State Flexibility:

- States should be allowed to use prior calendar year income for the purpose of making decisions for financial assistance for Exchange coverage in order to maintain their commitment to reducing avoidable churn, dis-enrollment for procedural reasons, and administrative burden.
- Federal policy should support States that choose to make coverage decisions using prior calendar year income for Exchange coverage, without a beneficiary request for coverage, but with notification to the beneficiary and ability to opt out.
- CMS should provide additional technical assistance to states interested in leveraging these flexibilities and streamline processes and approval wherever possible.

In addition to the framework and principles, the Enrollment Coalition has started efforts to draft legislative language that would effectuate these ideas. The draft legislation would provide the Secretary of Health and Human Services the authority to approve a state autoenrollment demonstration program in which the state, using prior year income tax data, or other reliable sources of income data, automatically enrolls an individual or family into coverage with a zero dollar premium (taking into consideration any subsidies for which the individual or family is eligible). As a coalition representing multiple voices of the health care sector, including payors, providers, and patients, who have come together to support an autoenrollment policy, the Enrollment Coalition would be pleased to further discuss this topic with CMS.

Thank you for your consideration of these comments.

Sincerely,
The Enrollment Coalition