



PROPOSED ACTION  
MEMORANDUM

# Reversing Key Sabotage Efforts and Increasing Access to Affordable Care Act Coverage

Department of Health and Human Services  
December 2020

# I. Summary

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The Affordable Care Act (ACA) contains powerful tools to extend quality, affordable health insurance to millions more Americans. But these tools have been undermined or ignored by the Trump administration, leading to the lowest enrollment levels since 2016.

To address this harm, the Department of Health and Human Services (Department) could immediately issue and finalize a limited “market modernization” rule that permanently reverses some of the Trump administration’s most harmful changes and expands access to ACA coverage. These changes would be consistent with the campaign’s pledge to protect and build on the ACA, lower health care costs, and make coverage more affordable and comprehensive for millions of people.

This memorandum recommends that the Department adopt at least the following eight priority policies in a market modernization rule. But there is flexibility to include more, fewer, or different policies than those outlined here. These eight key priorities are to:

- (1) Permanently extend the annual open enrollment period to ninety days.
- (2) Create two new permanent special enrollment periods for: (i) those whose income is between 100% and 250% of the federal poverty level, and (ii) those who lose a job even without the loss of other coverage.
- (3) Reverse changes to the premium adjustment percentage to make coverage more affordable.
- (4) Eliminate enrollment bars for premium nonpayment.
- (5) Increase standards for direct enrollment and enhanced direct enrollment pathways.
- (6) Eliminate the double billing rule for non-Hyde abortion services.
- (7) Eliminate burdensome essential health benefits reporting requirements.
- (8) Eliminate burdensome failure to reconcile requirements.

## II. Justification

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Although the Exchanges are stable, overall enrollment has declined each year since a peak of nearly 12.7 million enrollees in 2016.<sup>1</sup> By the 2020 open enrollment period (OEP), enrollment had dropped to 11.4 million individuals,<sup>2</sup> even as the uninsured rate has risen. This decline is attributed in large part to policies adopted by the Trump administration.

Given the rising uninsured rate and the COVID-19 crisis, there is an urgent need to permanently reverse Trump-era policies and adopt near-term changes that enable more people to enroll in ACA coverage. Quickly issuing a “market modernization” rule would make immediate changes ahead of the 2022 plan year, blunt industry opposition to policy changes, inform the public that high-quality coverage is available, and enable quick (albeit limited) action to temper the sale of non-ACA plans.

A “market modernization” rule is needed regardless of whether the Trump administration finalizes its proposed Notice of Benefit and Payment Parameters for 2022 (2022 Notice) before Inauguration Day.<sup>3</sup> If the 2022 Notice is *finalized*, the Department may want to reverse some of the changes in that rule in the “market

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<sup>1</sup> See U.S. Department of Health and Human Services, Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report, (Mar. 11, 2016), <https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf>.

<sup>2</sup> See U.S. Department of Health and Human Services, Health Insurance Exchanges 2020 Open Enrollment Report, (Apr. 1, 2020), <https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf>.

<sup>3</sup> See 85 Fed. Reg. 78572-682 (Dec. 4, 2020). Comments on the proposed 2020 Notice are due on December 30, 2020. It remains to be seen whether the Department, alongside the Department of the Treasury, will be able to finalize this rule by January 20, 2021.

modernization” rule. Top priorities include changes regarding Exchange Direct Enrollment (DE) options, the user fee, and Section 1332. If the 2022 Notice is *not finalized* by Inauguration Day, the Department could decline to move forward with harmful changes. But it would not be able to adopt new policies not already proposed in the 2022 Notice, meaning a “market modernization” rule is still necessary to reverse key sabotage efforts and expand access to coverage.

### III. Proposed Action

The “market modernization” rule would be similar in form to the “market stabilization” rule (2017 Trump Rule), a regulation put in place during the first ninety days of the Trump administration. That omnibus rule made swift changes that insurers had long argued were needed to “stabilize” the Exchanges and that had the effect of making it more challenging for individuals to enroll in ACA coverage.

A market modernization rule could incorporate many changes, but this memo identifies eight priority policies that could be implemented quickly and that are consistent with the near-term goals of (i) maximizing the number of people with an opportunity to enroll in ACA coverage, and (ii) reducing administrative burdens on consumers and states. This chart summarizes these priority changes, which are described in more detail below.

Regulatory Provision(s)	Current Policy	Proposed Change	Proposed Effective Date
45 C.F.R. § 155.410(e)	Annual open enrollment period is Nov. 1 to Dec. 15	Set annual open enrollment period from Nov. 1 to Jan. 31	Benefit years beginning on or after Jan. 1, 2022
45 C.F.R. § 155.420(d)	N/A	Authorize two new special enrollment periods for (i) those whose income is <250% FPL; and (ii) job loss	60 days of publication
45 C.F.R. § 156.130(e)	Premium adjustment percentage is calculated using job-based plan premiums and individual market premiums	Revert to an Obama-era policy where the premium adjustment percentage is based only on job-based plan premiums	Benefit years beginning on or after Jan. 1, 2022
45 C.F.R. § 156.270	Insurers can refuse to issue new coverage to those who owe past-due premiums for prior coverage	Revert to an Obama-era policy where insurers cannot refuse to issue new coverage due to past-due premiums	60 days of publication
45 C.F.R. § 155.221(b)	DE entities face few limits on the sale of non-ACA products, no standardized requirements for Medicaid referrals, and can influence consumer plan selection	Prohibit DE entities from marketing non-ACA plans, influencing plan selection, or selling or disclosing applicant information; require DE entities to make Medicaid referrals	Nov. 1, 2021 (to coincide with the 2022 OEP)
45 C.F.R. § 156.280(e)(2)(i)	Insurers must send, and consumers must pay, a separate bill for the portion of premium required for non-Hyde abortion services	Revert to an Obama-era policy where insurers have flexibility to meet statutory requirements, including through a single bill and payment	60 days of publication
45 C.F.R. § 156.111 (d)(2), (f)	States must submit an annual report on mandated benefits that exceed the essential health benefits in their state	Revert to an Obama-era policy that defers to state judgment; provide technical assistance as needed but with no specific reporting requirements	60 days of publication
45 C.F.R. § 155.305(f)(4)	Individuals who fail to file a tax return and reconcile advance premium tax credits lose eligibility for future subsidies	No longer condition eligibility for subsidies based on whether an enrollee has filed a tax return and reconciled their advance premium tax credits	60 days of publication

The Department should immediately issue a notice of proposed rulemaking for the market modernization rule, hold a thirty-day comment period, and issue a final rule as quickly as possible. Doing so would be consistent with speedy adoption of the 2017 Trump Rule. That rule was issued on February 10, 2017, (with a

twenty-day comment period) and finalized on April 13, 2017.<sup>4</sup> The 2017 Trump Rule went into effect sixty days after publication and applied to 2018 plans. Swift finalization was needed because the changes affected plan designs and rates for 2018.<sup>5</sup> In swiftly adopting the rule, the Department additionally cited (i) the need to improve quickly the risk pool and increase market stability, (ii) the rule's limited number of changes, and (iii) the submission of more than 4,000 comments, suggesting that stakeholders had an opportunity to participate in the rulemaking process.

These justifications could apply equally to a market modernization rule. The Administrative Procedure Act (APA) does not specify a minimum duration for comment periods; this standard is satisfied so long as the public has a reasonable and meaningful opportunity to participate in the rulemaking process.<sup>6</sup> Further, many of the proposed changes are reversals of prior policies, enabling the Department to draw from prior comments. So long as the Department carefully considers all comments and stakeholder reliance interests, a procedural APA challenge is unlikely to succeed. Because a handful of the policies are new and have not been formally considered before, a thirty-day (rather than a twenty-day) comment period is recommended.<sup>7</sup>

Where a reversal to a prior policy is recommended, the Department must explicitly acknowledge its change in position, offer a reasoned explanation as to why it is changing its interpretation, consider alternatives (including the current policy), and address the effect on any reliance interests that would be affected by reversing prior policy (identifying such interests and explaining how they've been taken into account or why it isn't appropriate to do so).<sup>8</sup> A detailed justification is especially important when the "new policy rests upon factual findings that contradict those which underlay its prior policy" or the "prior policy has engendered serious reliance interests."<sup>9</sup> Each section of this memo includes legal and policy arguments that the Department could make to justify each change.

## (1) Permanently Extend the OEP to Ninety Days from November 1 to January 31

**Current state:** Since the 2018 plan year, the OEP has run for forty-five days on an annual basis from Nov. 1 to Dec. 15. However, this has not always been true: the initial OEP for 2014 lasted 180 days, and the OEPs for 2015, 2016, and 2017 lasted 90 days.<sup>10</sup> The 2018 OEP was set for ninety days but was later halved by the Trump administration, which set a permanent forty-five-day OEP via the 2017 Trump Rule.<sup>11</sup> The shortened OEP—combined with funding cuts for outreach and education—led to consumer confusion and contributed to stagnant enrollment through HealthCare.gov.

**Proposed action:** The Department should adopt a permanent OEP of at least ninety days beginning with the 2022 plan year.<sup>12</sup> The Secretary has broad discretion to establish annual OEPs for the Exchanges,<sup>13</sup> and the Department has used this discretion to adopt varied OEPs over time. While this memorandum

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<sup>4</sup> 82 Fed. Reg. 18346-82 (Apr. 18, 2017); 82 Fed. Reg. 10980-98 (Feb. 17, 2017). Some of the rule's changes have been challenged in *Columbus v. Trump* (No. 1:18-cv-02364), a global challenge to the Trump administration's efforts to undermine the ACA.

<sup>5</sup> *Id.* at 18348-49.

<sup>6</sup> See *Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1117 (D.C. Cir. 2019).

<sup>7</sup> See *Azar v. Allina Health Services*, 139 S. Ct. 1804, 1809 (2019) (suggesting that the "APA minimum" period for public notice-and-comment is 30 days even though the APA does not specify a minimum requirement).

<sup>8</sup> *Dep't of Commerce v. New York*, 588 U.S. \_\_\_, 139 S.Ct. 2551, 2575-76 (2019); *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (1999) (*Fox*). The agency's burden is to convince a reviewing court that the new policy is permissible under the relevant statute, there are good reasons for it, and the agency believes it to be better. *Fox* at 515.

<sup>9</sup> *Fox* at 515; see also *DHS v. Regents of the University of California* 140 S. Ct. 1891, 1914-15 (2020).

<sup>10</sup> 81 Fed. Reg. 12204, 12273-74 (Mar. 8, 2016); 80 Fed. Reg. 10750, 10794-95 (Feb. 27, 2015); 79 Fed. Reg. 13744, 13796-97 (Mar. 11, 2014); 77 Fed. Reg. 18310, 18387-90 (Mar. 27, 2012).

<sup>11</sup> 82 Fed. Reg. at 18353-54 (setting the 2018 OEP and annual OEPs thereafter from Nov. 1 to Dec. 15).

<sup>12</sup> This policy must be combined with increased funding for advertising, outreach, and education. But these changes can be made operationally without the need for immediate regulatory changes.

<sup>13</sup> See 42 U.S.C. § 18031(c)(6)(B).

recommends an annual OEP from November 1 to January 31, the Department could solicit comment on alternative timeframes, including aligning the OEP with tax filing season.

In reestablishing a ninety-day OEP, the Department should cite the need to attract new enrollees, an important indicator of Exchange stability, because new enrollees tend to be younger and healthier and thus help maintain a stable risk pool. During the 2020 OEP, only 25% of consumers were new enrollees, down from the peak of 39% for 2016.<sup>14</sup> While advertising and outreach will help reach new enrollees, many may need more than forty-five days to complete the enrollment process, a concern previously raised by commenters.<sup>15</sup>

The Department should also point to the successful experiences of State-Based Exchanges, nearly all of which offer an extended OEP relative to HealthCare.gov.<sup>16</sup> This experience suggests that longer OEPs do not result in increased adverse selection, a claim made by the Trump administration that was not supported by evidence.<sup>17</sup> For the 2019 and 2020 OEPs, enrollment through the State-Based Exchanges increased while enrollment through the Federal Exchange decreased or remained flat.<sup>18</sup> Comparing the State-Based Exchange enrollment data to the Federal Exchange data (including, if possible, the additional enrollment in State-Based Exchanges during the period that extended beyond the forty-five-day federal period) could provide powerful support for the change—together with data showing that the State-Based Exchanges did not see adverse selection as a result.

It is true that the Obama administration would have shifted to a forty-five-day enrollment period beginning with the 2019 OEP.<sup>19</sup> However, that change was adopted in 2016, when enrollment had increased each year since 2014. Circumstances have clearly changed, and the Department can justify a longer OEP relative to recent years by citing consistent enrollment declines since 2016 and a higher uninsured rate. The Department can indicate that it will consider shortening the OEP in the future if the circumstances warrant doing so, but a longer OEP is warranted at this time.

Finally, a ninety-day OEP will further help ensure that as many consumers as possible can access comprehensive coverage, and do not mistakenly fall prey to non-ACA plans that put consumers at risk of higher costs and undermine the ACA risk pools. A longer OEP will enable greater enrollment in ACA coverage thereby extending ACA consumer protections, like coverage for preexisting conditions, to more people.

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<sup>14</sup> U.S. Department of Health and Human Services, *supra* note 2 at 4; U.S. Department of Health and Human Services, *supra* note 1 at 9.

<sup>15</sup> See 82 Fed. Reg. at 18354.

<sup>16</sup> State-Based Exchanges cannot adopt their own OEPs but can “supplement” the federally-set OEP with a special enrollment period “as a transitional measure.” 82 Fed. Reg. at 18355.

<sup>17</sup> 82 Fed. Reg. at 18353-54. Enrollment data is inconclusive as to whether a longer OEP increases the risk of adverse selection—or decreases it by encouraging healthier people to enroll. See Paul Shafer & Stacie Dusetzina, Looking Ahead to 2018: Will A Shorter Open Enrollment Period Reduce Adverse Selection in Exchange Plans? Health Affairs Blog (Apr. 14, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170414.059663/full/>.

<sup>18</sup> See Katie Keith, Final Marketplace Enrollment Data for 2020, Health Affairs Blog (Apr. 2, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200402.109653/full/>.

<sup>19</sup> 81 Fed. Reg. at 12274.

## (2) Create Two New Special Enrollment Periods (SEPs)

**Current state:** Individuals can qualify for an SEP for a variety of reasons, including the loss of minimum essential coverage (MEC), marriage, birth or adoption, a permanent move, or newly gained immigration status.<sup>20</sup> Although specific coverage rules vary, each of these qualifying life events results in a sixty-day period of SEP eligibility. SEPs are not currently available for those who are low-income but missed the OEP, or for those who lose their job without also losing MEC.

**Proposed action:** The Department can better address these challenges by authorizing new permanent SEPs for: (i) those whose income is between 100% and 250% of the federal poverty level (FPL), and (ii) the loss of a job even without the loss of MEC. The rule should also authorize Exchanges to waive pre-enrollment verification requirements for SEP eligibility.

Relevant to both changes, the Secretary has broad authority to establish Exchange SEPs and regulate the Exchange more generally.<sup>21</sup> Both the Obama and Trump administrations have leveraged this authority to adopt extra-statutory SEPs. For instance, the Obama administration adopted explicit SEPs for victims of domestic violence, for those whose enrollment resulted from an error, and for “exceptional circumstances.”<sup>22</sup> The Trump administration created an SEP for those who newly gain access to certain health reimbursement arrangements.<sup>23</sup> State-Based Exchanges have adopted a range of SEPs broader than the federal SEP standards.<sup>24</sup>

**Low-income SEP.** The Department should create a permanent SEP for individuals who otherwise qualify for ACA coverage and whose income is between 100% and 250% of the FPL, meaning they qualify for advance premium tax credits (APTCs) and cost-sharing reduction subsidies (CSRs). This could take the form of a “continuous” SEP, allowing qualifying low-income individuals to enroll in Exchange coverage once per month. Alternatively, the policy could be modeled after a policy in Massachusetts, which provides a sixty-day SEP if an individual is determined newly eligible for subsidized coverage or has not previously applied for subsidized coverage. Exchange eligibility requirements would otherwise apply, but applicants would not have to have prior coverage to be eligible for this SEP.

This SEP would be unique relative to existing SEPs because it would not be time-limited based on a change in an applicant’s status or an external qualifying event. Instead, an individual or family who meets the requirements above could enroll at any time during the year based on their income or upon learning of their eligibility for APTCs and CSRs.

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<sup>20</sup> See 45 C.F.R. § 155.420. Even though millions qualify each year, SEPs remain underutilized, with fewer than 15 percent of eligible people taking advantage of SEPs to enroll in ACA coverage. See Stan Dorn, Helping Special Enrollment Periods Work Under the Affordable Care Act, Urban Institute (Jun. 2016), <https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>; Matthew Buettgens, Stan Dorn, and Hannah Recht, More Than 10 Million Uninsured Could Obtain Marketplace Coverage Through Special Enrollment Periods, Urban Institute (Nov. 2015), <http://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>.

<sup>21</sup> See 42 U.S.C. § 18031(e)(6)(C) (authorizing the Secretary to provide for SEPs under HIPAA and circumstances similar to Medicare Part D); 42 U.S.C. § 300gg-1(b)(3) (directing the Secretary to establish market wide SEPs for qualifying events under ERISA); see also 42 U.S.C. § 18041(a) (providing broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges).

<sup>22</sup> See 45 C.F.R. § 155.420(d)(9)-(10), (12).

<sup>23</sup> See *id.* at (d)(14).

<sup>24</sup> Adney Rakotoniaina, How States Are Increasing Coverage Through Special Enrollment Periods, National Academy for State Health Policy (Sep. 28, 2020), <https://www.nashp.org/how-states-are-increasing-coverage-through-special-enrollment-periods/>.

Given this uniqueness, insurers will argue that such an SEP will result in adverse selection,<sup>25</sup> and is inconsistent with Section 1311(c)(6)(C) of the ACA and industry practice for employer-sponsored coverage, HIPAA, and Medicare Part D. They will also argue that this type of SEP is contrary to the ACA's statutory design because it erodes the law's requirement for one annual OEP with additional enrollment allowed only in special circumstances.

These arguments notwithstanding, the Department can respond in at least the three following ways. These responses could be made in addition to noting the broad authority to establish Exchange SEPs and generally regulate the Exchange as noted above.

One, the low-income SEP is consistent with existing SEPs under Medicare Part D and the Employee Retirement Income Security Act (ERISA). Section 1311(c)(6)(C) of the ACA requires exchanges to provide for SEPs "specified" under ERISA and other SEPs "under circumstances similar to" SEPs created under the Medicare Part D program. In administering the Medicare Part D program, Congress directed the Secretary to establish a range of additional SEPs.<sup>26</sup> Some of these SEPs are triggered by a change in an applicant's status or an external qualifying event (such as the loss of coverage or an enrollment error), but the statute also grants the Secretary with broad authority to establish SEPs for low-income individuals who are dually eligible for Medicare and Medicaid. In response, the Secretary adopted a "continuous" SEP for dual eligibles and other low-income enrollees to enroll in or change Medicare Part D plans once per month.<sup>27</sup> This continuous SEP was adopted in regulations in 2010 and remained in place until 2018, when the Trump administration replaced it with a once-per-quarter SEP.<sup>28</sup>

Medicare Part D and the ACA differ in several ways. For instance, the continuous SEP for low-income Medicare enrollees was primarily designed to enable beneficiaries to switch plans, rather than incentivize new enrollment. Even so, Section 1311(c)(6)(C) of the ACA directs Exchanges to provide SEPs "under circumstances similar to" SEPs created under the Medicare Part D program, including the SEPs created for low-income Medicare beneficiaries. The Medicare statute granted broad authority to the Secretary to create and modify SEPs in administering the Medicare Part D program, and, by referring to this authority under Section 1311 of the ACA, Congress granted the same authority to the Secretary in the context of administering the Exchanges. The Secretary can exercise this authority to allow a continuous SEP for low-income individuals.

A similar argument could be made under existing SEPs authorized by ERISA. Under 26 U.S.C. § 9801(f)(3), group health plans are required to provide a sixty-day SEP for employees who are eligible for, but not enrolled in, the group health plan, if the employee becomes eligible for state premium assistance under Medicaid or CHIP. The employee would have sixty days to request coverage under the group health plan after the date they are determined eligible. As with the Medicare Part D SEP, ERISA contemplates the need for more flexible SEPs for low-income people who qualify for federal coverage programs. The references to SEPs under ERISA and Medicare Part D in Section 1311 of the ACA provide sufficient justification for the Department to adopt a low-income SEP.

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<sup>25</sup> In a 2012, the Department adopted an SEP for individuals who are determined newly eligible or ineligible for APTC or who had a change in CSR eligibility. *See* 77 Fed. Reg. 18310, 18463 (Mar. 27, 2012) (authorizing an SEP through the Exchange for an individual "determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP"). This SEP was subsequently restricted in a 2013 rule. *See* 78 Fed. Reg. 42160, 42263-64 (Jul. 15, 2013) ("Due to ongoing considerations regarding the risk pool, we are finalizing our proposed modifications to paragraph (d)(6) to specify that this special enrollment period only applies to those individuals who are already enrolled in a QHP through the Exchange."). Additional restrictions and changes to these requirements have been adopted over time. *See* 45 C.F.R. § 155.420(d)(6).

<sup>26</sup> *See* 42 U.S.C. § 1395w-101(b)(3).

<sup>27</sup> Previously, the Department allowed enrollment or disenrollment at any time, including when "[t]he individual is a full-subsidy eligible individual or other subsidy-eligible individual as defined in § 423.772 of this part." *See* 75 Fed. Reg. 19678, 19720 (Apr. 15, 2010) (conforming regulations with current practice outlined in HHS guidance).

<sup>28</sup> *See* 42 C.F.R. § 423.38(c)(4). The Department considered allowing this SEP only once per year with certain exceptions but opted to instead allow two to three uses of the SEP per year. 83 Fed. Reg. 16515 (Apr. 16, 2018). The Department reported that this SEP is rarely used and, when used by beneficiaries, used only once per year. *Id.*

Two, the Department has the authority to offer SEPs that promote the ACA's overall goal of expanding health coverage and promoting Exchange viability under Section 1321(a) of the ACA. This proposed SEP would not disturb the requirement to provide ACA-specified SEPs, and is consistent with the Secretary's broad discretion to set Exchange requirements that are appropriate to support Exchange viability and consistent with the goals of the ACA.<sup>29</sup> Extra-statutory SEPs have been adopted by both the Obama and Trump administrations to expand access to Exchange coverage.

The SEP will improve Exchange viability by increasing marketplace enrollment. Millions already qualify for, but are not enrolled in, subsidized Exchange coverage. In 2018, those with incomes between 100% to 200% of the FPL accounted for 28% of the total uninsured population.<sup>30</sup> More recent data suggests that 19% of the nation's 29.8 million uninsured people qualified for, but did not enroll in, subsidized Exchange coverage in 2019.<sup>31</sup> And an estimated 4.7 million uninsured people qualify for a no-premium Exchange plan.<sup>32</sup> Despite the availability of subsidies, millions remain uninsured because they are unaware of ACA coverage options or because the enrollment process is too daunting.<sup>33</sup> A low-income SEP could help reduce this gap by extending coverage to low-income families when they become aware of ACA coverage, even if outside of the OEP.

Though insurers will argue that the SEP will lead to adverse selection, those eligible for the low-income SEP will be more motivated to enroll in coverage because of generous subsidies, rather than a health need. And the remaining uninsured are disproportionately under age thirty-five,<sup>34</sup> meaning this SEP could increase enrollment of younger consumers thereby improving the health of the risk pool and lowering premiums.

Three, the Department can look to the success of a similar enrollment policy in Massachusetts, where individuals whose income is up to 300% of the FPL qualify for ConnectorCare coverage, which is subsidized by the state and federal government. ConnectorCare is available outside of the annual OEP (*i.e.*, an individual qualifies for a sixty-day SEP) if the individual is determined newly eligible for ConnectorCare coverage or has not previously applied for ConnectorCare coverage.<sup>35</sup> This policy has been in place since the ConnectorCare program was created, and there appears to be no evidence of adverse selection.<sup>36</sup> To the contrary, Massachusetts has the highest rate of insured residents, the lowest average Exchange premiums, and record-high Exchange enrollment.<sup>37</sup> The Massachusetts Health Connector even conducts year-round outreach and marketing campaigns, recognizing that many of the Commonwealth's uninsured residents could become eligible for ConnectorCare coverage at any point during the year.<sup>38</sup> Empirical data on Massachusetts experience would help bolster the justification for the change.

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<sup>29</sup> Similar arguments were made in the 2017 Trump Rule. See 82 Fed. Reg. at 18364 ("Given that there is nothing in section 1311(c)(6)(C) of the PPACA that otherwise limits the Secretary's broad discretion under section 1321(a) of the PPACA, we believe we may place reasonable limits on access to special enrollment periods that promote the overall goal of the PPACA to ensure continuous health coverage and the viability of Exchanges."). In *Chicago v. Azar* (No. 1:20-cv-01566)—litigation over the Trump administration's refusal to allow a broad-based SEP in response to the pandemic—the government repeatedly cited "broad discretion" to manage and provide SEPs under 42 U.S.C. § 18031(c)(6)(C).

<sup>30</sup> Jennifer Tolbert et al., Key Facts About the Uninsured Population, Kaiser Family Foundation (Dec. 13, 2019), <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>; see also Stan Dorn, How States Can Use New Revenue to Lower Consumer Costs for Individual Health Insurance, Families USA (Mar. 13, 2020), <https://familiesusa.org/resources/how-states-can-use-new-revenue-to-lower-consumer-costs-for-individual-health-insurance/>.

<sup>31</sup> Congressional Budget Office, Who Went Without Health Insurance in 2019, and Why? (Sep. 30, 2020), <https://www.cbo.gov/publication/56504>.

<sup>32</sup> Rachel Fehr, Cynthia Cox, and Matthew Rae, How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020? Kaiser Family Foundation (Dec. 10, 2019), <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020>.

<sup>33</sup> See Amy E. Cha & Robin A. Cohen, Reasons for Being Uninsured Among Adults Aged 18-64 in the United States, 2019, National Center for Health Statistics Data Brief No. 382 (Sep. 2020), <https://www.cdc.gov/nchs/products/databriefs/db382.htm>.

<sup>34</sup> Munira Z. Gunja & Sara R. Collins, Who Are The Remaining Uninsured, And Why Do They Lack Coverage? The Commonwealth Fund (Aug. 28, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage>.

<sup>35</sup> See 956 Mass. Reg. 12.10(1)(b), (c).

<sup>36</sup> See Sarah Lueck, Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage, Center on Budget and Policy Priorities (Jun. 5, 2019), <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>.

<sup>37</sup> Massachusetts Health Connector, Commonwealth Health Connector Insurance Authority: Strategic Plan 2020-2022, <https://www.mahealthconnector.org/wp-content/uploads/MA-Health-Connector-Strategic-Plan-2020-2022.pdf>.

<sup>38</sup> Massachusetts Health Connector, Report to the Massachusetts Legislature: Activities and Accomplishments of the Massachusetts Health Insurance Marketplace Fiscal Year 2019 (Jan. 2020), <https://www.mahealthconnector.org/wp-content/uploads/HealthConnectorAnnualReport2018.pdf>.



**Job loss SEP.** The Department has discretion to ensure that individuals can enroll in ACA coverage in the face of a significant life change. Being laid off or fired from a job, even without losing MEC, is a significant life change that should be treated as a qualifying event for purposes of an SEP. A job loss SEP is particularly important for those whose new income would qualify for subsidies.

As with the low-income SEP, insurers will raise concerns about adverse selection,<sup>39</sup> but job loss is unrelated to health care needs and typically outside of an employee's control. Employers generally cannot lay off or fire individuals solely because of a change in disability status or the need to take medical leave.<sup>40</sup> Further, individuals who face job loss may already be able to access an "exceptional circumstances" SEP. A uniform job loss SEP will help ensure that all those who face similar circumstances are able to access comprehensive ACA coverage in a timely manner.

This SEP would have a significant impact in extending access to coverage. A job loss SEP would extend coverage to the 20% of adults who were uninsured before losing their job (or who had their hours or pay cut) and thus do not have access to existing SEPs.<sup>41</sup> An estimated 39% of workers in industries that are especially vulnerable to job loss (such as restaurants and retail) would be eligible for subsidized Exchange coverage with a job loss or emergency SEP, compared to only 31% without an SEP.<sup>42</sup> Eligibility would be even greater in states that have not yet expanded their Medicaid programs. The need for a job loss SEP has been underscored by the pandemic but should be an ongoing and permanent SEP for all Exchanges.

**Effective date for both new SEPs.** This memorandum recommends that both the low-income SEP and the job loss SEP go into effect sixty days after the final rule is published in the *Federal Register*. Both SEPs would help respond to the pandemic and economic crisis, reduce the uninsured rate, and promote access to COVID-19 testing and a vaccine. While these changes should be permanent and are not COVID-19-specific, both will be valuable to adopt during 2021 as an added response to the pandemic.

But the Department may want to solicit comment on whether the effective date of these policies should be delayed to benefit years beginning on or after January 1, 2022, to align with the next OEP. Given the arguments that insurers are likely to make about adverse selection, delaying the effective date would help address insurer reliance interests and enable any anticipated premium costs from this policy to be included in premiums. At a minimum, the Department should acknowledge this concern and note that other Exchanges that have adopted these policies have not experienced adverse selection. The Department could also conclude that if it does not adopt these policies in 2021, it is likely to allow additional broad SEPs where anyone who is uninsured could enroll in coverage, as many of the State-Based Exchanges allowed throughout 2020. These more narrowly tailored SEPs may be preferable to insurers compared to ongoing broad SEPs.

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<sup>39</sup> One recent study suggested "potential adverse selection" after finding higher medical costs among Exchange members who enrolled during SEPs compared to OEP. See Laura F. Garabedian et al., "Costs Are Higher for Marketplace Members Who Enroll During Special Enrollment Periods Compared With Open Enrollment," *Health Affairs* (2020) 39(8). The study should be cited, but the Department should recognize that the findings are based on limited data from only one large national insurer from 2015 and 2016.

<sup>40</sup> The Americans with Disabilities Act, the Family Medical Leave Act, the Age Discrimination Act, the Pregnancy Discrimination Act, and other federal laws prohibit many employers from discriminating against employees based on disability status (which includes many types of medical conditions), medical conditions related to pregnancy or childbirth, or other qualifying conditions (including serious health conditions) under the Family Medical Leave Act.

<sup>41</sup> See Sara R. Collins et al., New Survey Finds Americans Suffering Health Coverage Insecurity Along With Job Losses, The Commonwealth Fund (Apr. 21, 2020) <https://www.commonwealthfund.org/blog/2020/new-survey-finds-americans-suffering-health-coverage-insecurity-job-losses>.

<sup>42</sup> Tara Straw, Sarah Lueck, and Aviva Aron-Dine, Congress Should Bolster ACA Marketplace Coverage Amid COVID-19, Center on Budget and Policy Priorities (May 18, 2020), <https://www.cbpp.org/research/health/congress-should-bolster-aca-marketplace-coverage-amid-covid-19>.

### (3) Reverse Changes to the Premium Adjustment Percentage to Maximize Affordability

**Current state:** The premium adjustment percentage (PAP) is a measure of premium growth determined by the Department on an annual basis.<sup>43</sup> The PAP is used to set the annual rate of increase for the ACA's maximum annual limit on cost-sharing, the required contribution percentage for exemption eligibility, and penalty amounts under the employer mandate.

Beginning with the 2015 payment rule,<sup>44</sup> the Department adopted a methodology based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Account (NHEA). This methodology was selected because it reflected health care cost trends without being skewed by individual market premium fluctuations. This methodology was used until the 2020 payment rule, when the Department adopted an alternative premium measure that additionally captures increases in individual market premiums.<sup>45</sup> The Department believed the change more closely tracked premium trends for individuals and would reduce federal expenditures.<sup>46</sup> The Department maintained the same methodology for 2021.<sup>47</sup>

The new methodology inflated the PAP, resulting in a higher annual limit on out-of-pocket costs (which applies to individual and group plans), a higher required contribution from subsidy-eligible consumers, and higher employer mandate penalties. One estimate suggested that the increased PAP would result in higher premiums for at least 7.3 million Exchange consumers by reducing their premium tax credits.<sup>48</sup> The Department's own estimates included a decrease in federal premium tax credit spending of \$980 million in 2020, \$1.04 billion in 2021, \$1.09 billion in 2022, and \$1.15 billion in 2023 due to 70,000 fewer Exchange enrollees in 2020 and each year thereafter. Some of these 70,000 individuals were projected to enroll in short-term plans, but the Department expected the majority to become uninsured.

**Proposed action:** The Department should revert to its prior methodology for determining the PAP and base its projections on average per enrollee premiums for eligible employer-sponsored health plans as published in the NHEA.<sup>49</sup> Doing so would ensure that consumers do not face needlessly inflated premiums, higher out-of-pocket costs, and limited access to Exchange subsidies.

The Secretary has broad authority to establish the PAP methodology. Under 42 U.S.C. § 18022(c)(4), the Secretary has discretion in (i) estimating the average per capita premium for health insurance coverage for the prior year, and (ii) determining the average per capita premium for 2013. The Obama administration's PAP methodology—in place for plan years 2015 through 2019—went unchallenged. Though its methodology was heavily criticized,<sup>50</sup> the Trump administration's authority to make the change has not been challenged in court.

In reverting to the prior PAP methodology, the Department should emphasize the need to promote affordability and stability in the Exchange market. The Department should acknowledge in the proposed and final rules that the revised PAP methodology could affect employers but cite concerns about decreased

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<sup>43</sup> 42 U.S.C. 18022(c)(4); 45 C.F.R. § 156.130(e).

<sup>44</sup> 79 Fed. Reg. 13743, 13801-04 (May 12, 2014).

<sup>45</sup> 84 Fed. Reg. 17454, 17537-43 (Apr. 25, 2019).

<sup>46</sup> *Id.* at 17538.

<sup>47</sup> 85 Fed. Reg. 29164, 29227-30 (May 14, 2020).

<sup>48</sup> Aviva Aron-Dine & Matt Broaddus, Change to Insurance Payment Formulas Would Raise Costs for Millions with Marketplace or Employer Plans, Center on Budget and Policy Priorities (Apr. 26, 2019), <https://www.cbpp.org/research/health/change-to-insurance-payment-formulas-would-raise-costs-for-millions-with-marketplace>.

<sup>49</sup> Recent legislation in the House and Senate has attempted to require this change in statute, but none of these bills have become law. *See, e.g.*, Patient Protection and Affordable Care Enhancement Act, H.R. 1425, tit. 1 § 102 (2020); Fair Indexing for Health Care Affordability Act, S.B. 2785 and H.R. 5291 (2019).

<sup>50</sup> 85 Fed. Reg. at 29229 (“All commenters on this proposal expressed concern with the rate of increase in the PAPI and related payment parameters.”); 84 Fed. Reg. at 17539 (noting that “[a]ll commenters on this topic expressed opposition to or concerns about the proposed change”).

enrollment, higher premiums, and higher out-of-pocket costs as a reason to revisit its methodology, especially in light of the pandemic and its aftermath. The Department could also review the two years of results since the change, explain the consequences in terms of enrollment and costs to low-income families, and conclude that the new methodology has not led to positive results and that the Department no longer sees the value of the new methodology.

## (4) Eliminate Enrollment Bars for Premium Nonpayment

**Current state:** Insurers can currently refuse to enroll an applicant in a new plan if the consumer fails to pay outstanding premium debt from the prior year. This policy allows insurers to lock consumers out of coverage that would otherwise be available during OEPs and SEPs if they cannot pay past-due premiums. In adopting this policy in 2017, the Department concluded that an insurer would not violate the ACA's guaranteed issue requirement by refusing to effectuate new coverage because of past due premiums under any of its products during the prior twelve months.<sup>51</sup>

This was a shift from prior rules, where the Department had interpreted the ACA's guaranteed issue requirement to mean that an insurer could not require payment for past-due premiums before effectuating new coverage in a different product.<sup>52</sup> Insurers could pursue collection efforts for past-due premiums but could not condition new coverage on payment of the amount due.

**Proposed action:** The Department should revert to its prior interpretation so that consumers receive the full benefit of the ACA's guaranteed issue protections. Doing so is more consistent with statutory requirements, and the new policy was not sufficiently evidence-based to be adopted in the first place. The policy also disproportionately harms those in areas with limited insurer competition.

The ACA's guaranteed issue statute does not include an exemption for the nonpayment of premiums (unlike provisions such as guaranteed renewability).<sup>53</sup> Rather, the text of the statute clearly requires health insurers to accept every employer and individual that applies for coverage, regardless of their health status or other factors. There is thus no basis for creating a broad exception to an otherwise exception-less statutory requirement. Although the statute is clear, the Department should note that it would reach the same conclusion even if there were some statutory ambiguity to resolve.

Further, the justifications for the current rule—insurers' concerns about gaming and a desire to promote continuous coverage—were not based on current evidence. Those insurer concerns stemmed from comments on a rule that was finalized in February 2013, before the Exchanges had even opened, and before there was real-world experience with issues such as grace periods and premium nonpayment.<sup>54</sup> The Department cited no additional evidence beyond these general concerns that enrollees were intentionally gaming prior rules to avoid paying premiums.<sup>55</sup>

The preamble should also recognize concerns raised in prior comments: that individuals fail to make payments for reasons unrelated to gaming the system, that insurers have other ways to recover past-due premiums, and that the current policy could hurt the individual market risk pool.<sup>56</sup> At least one insurer association has already urged the Department to waive the requirement to terminate coverage for

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<sup>51</sup> 82 Fed. Reg. at 18349-53.

<sup>52</sup> 82 Fed. Reg. at 18349. An insurer could refuse to effectuate new coverage if the consumer tried to renew existing coverage. However, this would be addressed under guaranteed renewability requirements, rather than guaranteed issue requirements. *See* 45 C.F.R. § 147.106(b)(1).

<sup>53</sup> Compare 42 U.S.C. § 300gg-2(b)(1) *with* 42 U.S.C. § 300gg-1.

<sup>54</sup> *See* 82 Fed. Reg. at 18349 (referring to 78 Fed. Reg. 13406, 13416 (Feb. 27, 2013)).

<sup>55</sup> *See id.*

<sup>56</sup> *See id.* at 18350-51.

nonpayment and requested flexibility to reinstate coverage for consumers who are terminated because of nonpayment.<sup>57</sup>

Finally, the current policy could keep many from accessing coverage they are otherwise entitled to. An estimated one in ten enrollees in the Federal Exchange had their coverage terminated for premium nonpayment during 2016, and 16% of these individuals reenrolled with the same insurer for 2017.<sup>58</sup> This data predates the pandemic, and the current economic situation may lead to many additional consumers being newly unable to make timely premium payments. Still others may not realize they need to formally cancel their coverage; instead, they simply stop paying premiums. This policy is also concerning for individuals who live in an area where only one insurer is available.<sup>59</sup>

To bolster its analysis, the Department should analyze its more recent data for purposes of the rule and solicit data from insurers on premium nonpayment. The Department should acknowledge that insurers may have relied on the prior policy in developing rates for 2021 and ask for comment on the rate impact going forward. The Departments should also solicit evidence on abuse of the prior nonpayment policy, the reasons why a consumer might fail to pay their premiums one year but still enroll in coverage in the next year, and data on whether the current policy was effective at ensuring that consumers paid past-due premiums (versus simply locking consumers out of future coverage).

## (5) Increase Standards for Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) Pathways

**Current state:** The Trump administration dramatically expanded the ability of insurers and web brokers to use DE and EDE pathways. DE was contemplated in spring 2013 but formally launched as a pilot program in fall 2013 in response to the challenging rollout of HealthCare.gov.<sup>60</sup> The Trump administration then created the EDE pathway, which allows the entire Exchange enrollment process to be completed on the website of a third party without requiring the consumer to ever visit or create an account with HealthCare.gov.

Concerns have long been raised about DE entities and the EDE process.<sup>61</sup> Critics argue that the Department is attempting to privatize core Exchange functions and delegate the plan shopping experience to private, self-interested companies. DE entities use screening tools that shift consumers towards non-ACA plans, in part because DE entities earn higher commissions for enrollment in non-ACA plans. Medicaid-eligible consumers face enrollment barriers because DE websites do not have the same “no wrong door” approach as the Exchanges. And DE websites prevent consumers from fully comparing plan options based on price and quality: unlike Exchange websites, DE entities do not have to present all available Exchange plans or comparable information. Consumers may not enroll in, or even see, the plan that would best meet their needs.

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<sup>57</sup> Association for Community Affiliated Plans, Letter to Seema Verma (Mar. 20, 2020), <https://www.communityplans.net/wp-content/uploads/2020/03/ACAP-COVID-19-CMS-Letter-032020.pdf>.

<sup>58</sup> 82 Fed. Reg. at 18377.

<sup>59</sup> Of those who lived in an area where their 2016 insurer was the only insurer available in 2017, 23 percent had their coverage terminated due to nonpayment in 2016 and reenrolled with the same insurer during the 2017 OEP. *Id.*

<sup>60</sup> See Dylan Scott, Why the White House’s Latest Plan Is Both Good and Bad for Obamacare, *Talking Points Memo* (Nov. 19, 2013); Timothy Jost, Implementing Health Reform: Final Letter to Issuers on Federally Facilitated and State Partnership Exchanges, Health Affairs Blog (Apr. 6, 2013), <https://www.healthaffairs.org/doi/10.1377/hblog20130406.029894/full/>.

<sup>61</sup> See 83 Fed. Reg. at 16982 (noting that “[m]ost commenters were concerned that enrollment through a non-governmental site would occur without proper oversight and controls”); Tara Straw, “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, Center on Budget and Policy Priorities (Mar. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes> (discussing a series of additional policies to expand the use of DE and EDE with the seeming goal of replacing the Exchanges with web-brokers altogether).

Despite these concerns, the Trump administration expanded these pathways and weakened prior oversight rules and audit requirements.<sup>62</sup> The Department also adopted standards to “streamline” the oversight of DE entities, with the goal of encouraging DE participation,<sup>63</sup> and continues to identify ways to expand DE and EDE, including through the proposed 2022 Notice.<sup>64</sup> The Department recently disclosed that one-third of all Federal Exchange enrollment occurs through DE and EDE entities,<sup>65</sup> but the Department may want to analyze additional data related to DE and EDE activities.

**Proposed action:** To address long-standing concerns and demonstrate that immediate action is being taken on the proliferation of non-ACA plans, the Department should require DE and EDE entities to meet new standards. At a minimum, the Department should require all DE and EDE entities to follow Department-set requirements for referrals to state Medicaid programs and prohibit all DE and EDE entities from (i) marketing non-ACA plans, (ii) implicitly making recommendations based on their display of qualified health plans, and (iii) selling or disclosing applicant information. (The scope of these changes or timeline of adoption may be affected by written agreements between the Department and DE entities; these agreements are not publicly available but should be reviewed and assessed in advance of rulemaking.)

As a legal matter, no ACA provision requires DE or EDE. These pathways—and the requirements that entities must comply with—fall under the discretion of the Department, which must ensure that these processes adequately protect consumers. While DE and EDE can promote continued access to ACA coverage when HealthCare.gov is unavailable, this benefit must be balanced against real risks to consumers. The proposed restrictions will protect consumers from inaccurate or misleading information, help tamper enrollment in non-ACA plans, and promote competition among plans. The proposed standards will better ensure that DE and EDE entities act in the best interest of Exchange consumers and not in a way that undermines the goals of the ACA to provide a “one-stop shop” for eligibility determinations, and enable comparison shopping among plans. Empirical data to document these adverse consequences would help bolster the policy justification for the change.

The Department should note that current DE rules have not sufficiently overcome broker incentives to enroll consumers in non-ACA plans.<sup>66</sup> The Department asserted that its current approach balances consumer confusion while allowing the marketing of “complementary” non-ACA plans “during a single shopping experience on non-Exchange websites.”<sup>67</sup> But these assertions are no longer based in reality, and the Department’s own actions to curb abuses by DE entities since then provide justification to revisit this policy. The Department has, for instance, issued guidance to identify examples of prohibited DE and EDE entity conduct regarding screening processes and the marketing of non-ACA plans.<sup>68</sup>

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<sup>62</sup> See 83 Fed. Reg. at 17048 (allowing DE entities to select their own auditor instead of requiring that a Department-approved third party perform audits of DE entities). This change has been challenged in *Columbus v. Trump*.

<sup>63</sup> 84 Fed. Reg. 17454, 17515-26 (Apr. 25, 2019). This appears to have been successful: as of November 2020, the Department had approved 43 DE entities to use EDE. Of these 36 entities, nine are approved to host an EDE platform that can be leveraged by other partners. Center for Consumer Information and Insurance Oversight, Entities Approved to Use Enhanced Direct Enrollment (as of Nov. 2, 2020), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/EDE-ApprovedPartners>.

<sup>64</sup> 85 Fed. Reg. at 78609-22.

<sup>65</sup> *Id.* at 78619; see also HHS, Agents and Brokers in the Marketplace (Oct. 30, 2020), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Agents-and-Brokers-in-the-Marketplace.pdf> (asserting that EDE helps (i) attract new consumers because 45 percent of EDE consumers with active plan selections were new (versus 31 percent of non-EDE consumers with active plan selections); and (ii) promote less expensive plans since EDE enrollees found plans that cost 25 percent less after premium tax credits relative to those who did not use EDE).

<sup>66</sup> 84 Fed. Reg. at 17524.

<sup>67</sup> *Id.*

<sup>68</sup> See e.g., 85 Fed. Reg. at 78616-18 (“We explained in the 2020 Payment Notice that we believe marketing some products in conjunction with QHPs may cause consumer confusion, especially as it relates to the availability of financial assistance for QHPs purchased through the Exchanges.”); Center for Consumer Information and Insurance Oversight, Guidance Regarding Website Display for Direct Enrollment (DE) Entities Assisting Consumers in States with Federally-Facilitated Exchanges (FFE) and State-Based Exchanges on the Federal Platform (SBE-FPs) (May 22, 2020), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/DE-Entity-Standards-of-Conduct-Website-Display.pdf>.

Even so, DE and EDE entities—both insurers and brokers—will claim that this reform is significantly disruptive. The reliance interests of DE and EDE entities must be identified and addressed in the preamble to the proposed and final rules.

Empirical data supported by the large number of documented instances of consumers being misled about non-ACA plans would also be very useful in explaining and justifying the change.<sup>69</sup> Even if some or all of the proposed changes are not ultimately adopted in a final rule, their proposal would send a strong message to DE and EDE entities on enforcement and could help curb abuses.

## (6) Eliminate the “Double-Billing” Rule for Non-Hyde Abortion Services

**Current state:** Section 1303 of the ACA requires insurers that offer qualified health plans with coverage for non-Hyde abortion services to charge and collect at least \$1 per enrollee per month for those services. These premium dollars must be deposited into a separate account, remain segregated from other funds, and used only for such abortion services. Both the Obama and Trump administrations provided guidance to insurers on compliance with Section 1303.<sup>70</sup> This prior interpretation had never been challenged in court.

In 2019, the Trump administration made an abrupt shift in its interpretation by issuing the “double billing” rule, which requires insurers to send (and consumers to pay) two separate bills: one for the coverage of non-Hyde abortion services and one for the coverage of all other services.<sup>71</sup> Consumers who fail to pay both bills could have their coverage terminated, and the rule was viewed as an effort to discourage insurers from covering non-Hyde abortion services (even though doing so is allowed under the ACA and several states mandate this coverage). The rule also included a nonenforcement policy so insurers could let enrollees who object to the coverage of non-Hyde abortion services for religious or moral reasons opt out of that coverage by not paying the separate bill.<sup>72</sup>

**Proposed action:** The double billing rule should be withdrawn, and the Department should revert to the interpretation that had been in place through 2019 (*i.e.*, the Department did not specify a method that an insurer must use to comply with Section 1303). Doing so is fully within the Department’s authority and bolstered by the fact that the double-billing rule has been vacated by multiple courts.<sup>73</sup> The Trump administration appealed these district court rulings to the Fourth and Ninth Circuit Court of Appeals, but the Department could ask for an abeyance (*i.e.*, ask to put the litigation on hold) while the Department proceeds

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<sup>69</sup> See, e.g., U.S. Government Accountability Office, Private Health Coverage: Results of Covert Testing for Selected Offerings, GAO-20-634R (Aug. 24, 2020), <https://www.gao.gov/products/GAO-20-634R>; U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk (June 2020), <https://degette.house.gov/sites/degette.house.gov/files/STL%20DI%20Report%2006%2025%2020%20FINAL.pdf>.

<sup>70</sup> 80 Fed. Reg. 10750, 10840-41 (Feb. 27, 2015) (“[S]ection 1303 of the Affordable Care Act and § 156.280 do not specify the method an issuer must use to comply with the separate payment requirement. As we described in the proposed rule, this provision may be satisfied in a number of ways.”); Center for Consumer Information and Insurance Oversight, CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act (Oct. 6, 2017), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf>.

<sup>71</sup> 84 Fed. Reg. 71674, 71683-95 (Dec. 27, 2019).

<sup>72</sup> *Id.* at 71705-06 (“We also will not take enforcement action against QHP issuers that, beginning upon the effective date of the final rule, modify the benefits of a plan either at the time of enrollment or during a plan year to effectively allow enrollees to opt out of coverage of non-Hyde abortion services by not paying the separate bill for such services, resulting in the enrollee having a modified plan that does not cover non-Hyde abortion services and that no longer obligates the enrollee to pay the required premium for such services.”). The Department made clear, however, that doing so would be “entirely optional” for an Exchange insurer and subject to state requirements. *Id.* at 71706.

<sup>73</sup> See *California v. Department of Health and Human Services*, No. 3:20-cv-00682 (N.D. Cal. Jul. 20, 2020), appeal pending, No. 20-16802 (9th Cir. docketed Sep. 17, 2020); *Planned Parenthood of Maryland v. Azar*, No. 1:20-cv-00361 (D. Md. Jul. 7, 2020), appeal pending, No. 20-2006 (4th Cir. docketed Sep. 18, 2020); *Washington v. Azar*, No. 2:20-cv-00047 (E.D. Wash. Apr. 9, 2020), appeal pending, No. 20-35521 (9th Cir. docketed Jun. 10, 2020). 85 Fed. Reg. 27550, 27599-601 (May 8, 2020) (delaying the rule’s effective date to August 2020 in light of COVID-19).

with a new rulemaking process.<sup>74</sup> This would allow the administration to avoid having to defend the current rule while the market modernization rule is being adopted.

While some insurers and State-Based Exchanges may have relied on the rule and updated their operations to comply, many objected to the rule's burdensome requirements and urged withdrawal.<sup>75</sup> This was true of most commenters who also objected to the rule.<sup>76</sup> In withdrawing the current double-billing rule, the Department could emphasize the lack of evidence: the Trump administration cited no new evidence to justify its abrupt shift, arguing largely that the prior interpretation did not adequately reflect Congress's intent.<sup>77</sup> The Department should also cite concerns about coverage losses, consumer confusion, and unnecessary administrative costs for states and insurers.<sup>78</sup> Finally, the Department could cite the need to provide state flexibility, eliminate burdens on insurers and State-Based Exchanges in light of the pandemic, and the ACA's goal of expanding (not restricting) access to coverage.

## (7) Eliminate Burdensome Essential Health Benefits Reporting Requirements

**Current state:** Section 1311 of the ACA allows states to mandate benefits that exceed the ten categories of essential health benefits (EHBs) required by the ACA.<sup>79</sup> However, the state must defray the cost of those new mandates through payments to enrollees or insurers. In the Notice of Benefit and Payment Parameters for 2021, the Department required each state to report annually on mandates that exceed the EHB, with an initial reporting deadline of July 1, 2021.<sup>80</sup> This policy is expected to impose administrative burdens on states and chill state efforts to modify or define benefits in a way that promotes comprehensive coverage under the ACA.

**Proposed action:** There is ample justification to withdraw this requirement, and states should not be forced to spend limited resources on unnecessary EHB reporting requirements. First, the Department should recognize that the changes are unnecessary and unjustified; the Department cited only general concerns that states are not complying with the defrayal requirement.<sup>81</sup> Second, the Department already has the authority to investigate compliance concerns, making annual reporting by all states unnecessary for oversight purposes.<sup>82</sup> Third, the new policy conflicts with long-standing flexibility offered to states as part of the EHB benchmark plan selection process. Each of these reasons—bolstered by the fact that state resources are strained because of the pandemic—could be cited as justification to revisit these reporting requirements, which will have not yet gone into effect.

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<sup>74</sup> Another option is to settle with the plaintiffs and file a joint motion to request a stay of the litigation. Abeyance may be more challenging to secure since briefing has been ongoing, but oral argument has not yet been scheduled in any of the challenges so abeyance may still conserve judicial resources.

<sup>75</sup> See, e.g., America's Health Insurance Plans, Comment Letter (Jan. 7, 2019), <https://beta.regulations.gov/comment/CMS-2018-0135-73991> (citing a survey of members with initial cost estimates of \$50,000 to \$7.5 million per insurer and annual cost estimates of \$70,000 to \$10.8 million per insurer); National Association of Insurance Commissioners, Comment Letter (Jan. 8, 2019), [https://www.naic.org/documents/index\\_health\\_reform\\_section\\_190108\\_naic\\_proposed\\_program\\_integrity\\_reg\\_comments.pdf](https://www.naic.org/documents/index_health_reform_section_190108_naic_proposed_program_integrity_reg_comments.pdf); Covered California, Comment Letter (Jan. 8, 2019), [https://hbex.coveredca.com/regulations/PDFs/CoveredCA\\_comments\\_ProgramIntegrity\\_1819.pdf](https://hbex.coveredca.com/regulations/PDFs/CoveredCA_comments_ProgramIntegrity_1819.pdf); Washington Health Benefit Exchange, Comment Letter (Jan. 8, 2019), <https://beta.regulations.gov/comment/CMS-2018-0135-73397>.

<sup>76</sup> 84 Fed. Reg. at 71684.

<sup>77</sup> *Id.* The ACA's legislative history suggests that the opposite is true: Congress enacted Section 1303 "after rejecting more extreme and restrictive alternatives that would have eliminated abortion coverage in the Exchanges or prohibited enrollees from using federal financial assistance to purchase a plan including abortion coverage." *Id.* at 71693.

<sup>78</sup> See *id.* at 71684, 71703.

<sup>79</sup> 42 U.S.C. § 18031(d)(3)(B).

<sup>80</sup> 85 Fed. Reg. at 29218-26. The annual report must identify current benefit requirements, determine which benefits are in addition to EHB and thus require defrayal, and discuss the basis for the state's determination.

<sup>81</sup> *Id.* at 29219-20.

<sup>82</sup> *Id.*

## (8) Eliminate Burdensome Failure to Reconcile Requirements

**Current state:** Under the ACA, the amount that a taxpayer received in APTC must be reconciled with the amount of premium tax credit allowed.<sup>83</sup> The reconciliation process is used to determine whether the taxpayer owes excess APTC to the government (subject to repayment limits for some enrollees) or is owed additional premium tax credit by the government. Currently, a tax filer's failure to reconcile bars them from receiving APTC in the future, leaving them responsible for the full cost of premiums until they reconcile past APTC.

**Proposed action:** As outlined in a separate Roadmap 2021 memorandum, the Department should eliminate this "failure to reconcile" requirement and no longer condition continued eligibility for APTC on whether an individual has reconciled APTC. The current policy is not required under the ACA and imposes an unnecessary and severe penalty on low-income consumers. The Internal Revenue Service has sufficient alternative tools to promote compliance with its independent requirements to file a tax return and reconcile APTC, such that separate enforcement by the Department is not needed. This policy has caused significant administrative headaches for enrollees during the 2021 OEP (due to delays in processing tax returns) and should be eliminated permanently.

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<sup>83</sup> See I.R.C. § 36B(f); 26 C.F.R. § 1.36B-4.



