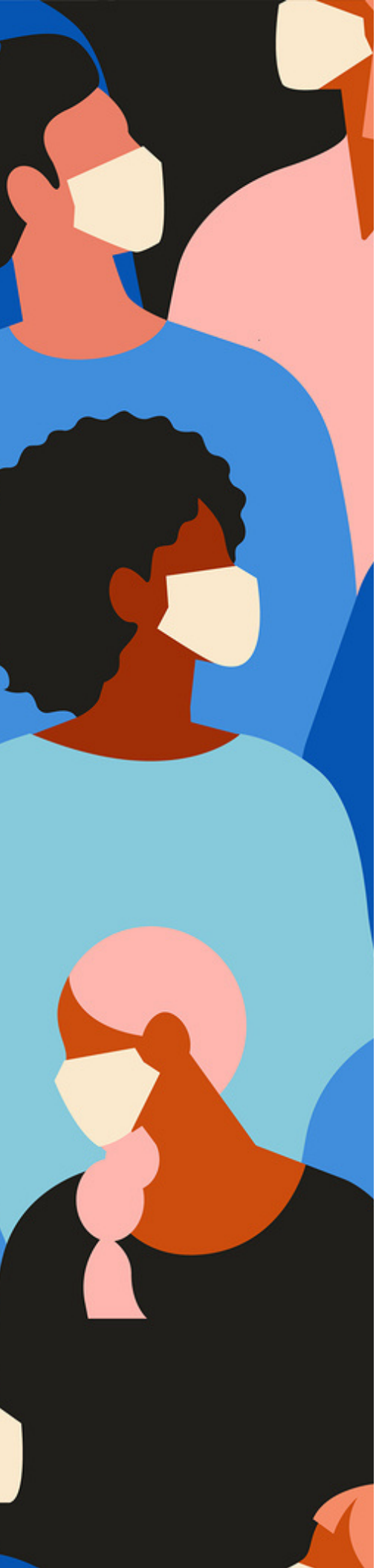


The Honorable Joseph Biden
President of the United States,
Washington, DC 20500

The Honorable Nancy Pelosi
Speaker of the House,
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Republican Leader,
U.S. House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Democratic Leader,
U.S. Senate
Washington, DC 20510

The Honorable Mitch McConnell
Republican Leader,
U.S. Senate
Washington, DC 20510

JUNE 29, 2021

DEAR PRESIDENT BIDEN, SPEAKER PELOSI, AND LEADERS SCHUMER, MCCONNELL, AND MCCARTHY:

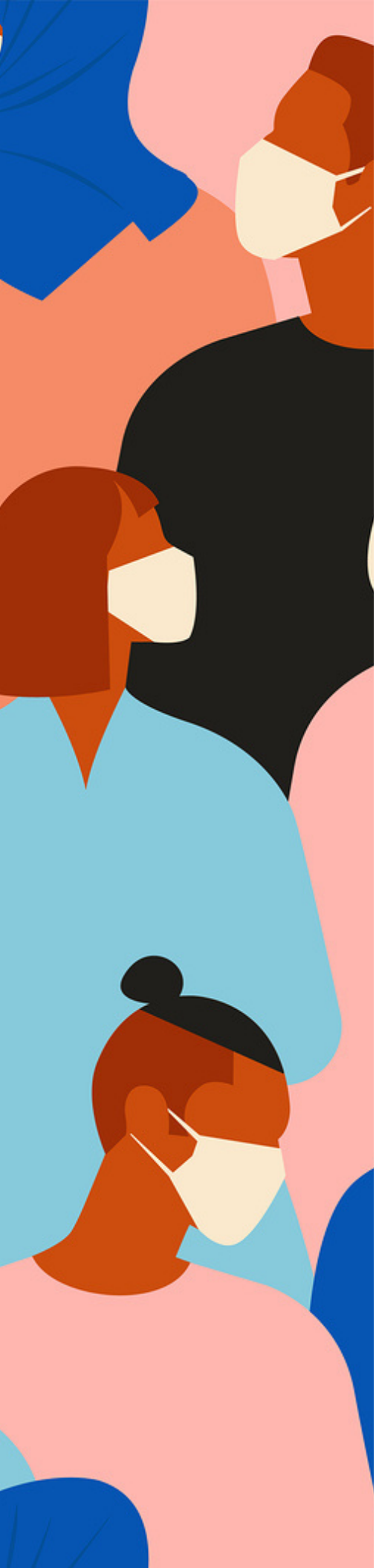
Thank you for your work to address the health and well-being of individuals, families and communities through the passage of the American Rescue Plan Act. While this is an important step in addressing the needs of millions of people affected by the pandemic, it is insufficient. The ongoing economic and public health distress of COVID-19 affects all of us, but it does not affect us all equally. What has been laid bare over the last 18 months are the deep structural inequities in access to affordable health care and to basic needs such as housing, fair wages, and infrastructure resources – inequities rooted in structural racism that put communities of color at greater risk of COVID-19. We must take specific actions to address these longstanding inequities.

As health advocates, we have continued to work to build upon and strengthen the Affordable Care Act at the state level since its passage. From state-directed cost containment strategies to coverage expansions for those excluded from federal programs, our states are proven leaders in driving innovative, equitable pathways to affordable health coverage. As you know, states are where policy innovation happens, providing federal decision makers with new models and approaches to deploy at a national scale. As such, we ask that any economic recovery package and adjacent administrative agenda be designed to encourage state efforts to expand equitable access to high quality health care and coverage that is rooted in equity.

Community Catalyst, in coordination with the undersigned state consumer health advocacy organizations from across the country, has developed a list of priority actions for Congress and the Biden Administration outlined in the attached issue brief that would:

- Improve affordability and quality of coverage;
- Expand access to comprehensive coverage; and Strengthen
- existing programs to better serve consumers.

All of these priorities are guided by the underlying and urgent need to advance health justice and racial equity. Just as Black and brown people suffered increased COVID-19 illness and death, they also had higher uninsured rates prior to the pandemic. These



communities have faced years of discrimination in employment and education, and continue to face barriers to accessing the care they need. As a result, they are more likely to work in low-wage jobs without good benefits like health coverage. The Affordable Care Act and Medicaid are critical to helping people gain access to affordable coverage, but more must be done to open up coverage opportunities, especially for those excluded from programs and resources. We have a clear moment of opportunity to strengthen the underlying policies of the ACA and Medicaid and reorient them toward racial justice and health equity.

Our unique consortium of consumer health advocates represents states across the country who have spent years investing in the success of the Affordable Care Act (ACA) and Medicaid in their respective states. Our states were the first to adopt state-based Marketplaces, embrace the goals of new coverage programs and continue to advance coverage and affordability work in their states when the work at the federal-level stalled. These states are laboratories for innovation in health care policy and, therefore, in addition to our priority actions for federal policymaking, we have highlighted examples from these states that can serve as models in health policy innovation as federal policymakers consider future reforms.

Your leadership and support for all communities across the country is vital to our collective success as a nation. We know that you, and your dedicated staff, have many important priorities to address, and we hope that the recommendations offered above will help shape our nation's response going forward. As advocates working across a diverse set of states to drive innovation and equitable pathways to high quality, affordable coverage, we are well-positioned to do more and are seeking support from federal stakeholders to advance a pro-innovation agenda. We look forward to an opportunity to further engage and meet with you staff to discuss these important priorities.

Thank you again for your efforts and your consideration,

Colorado Consumer Health Initiative
Community Catalyst
Community Service Society
Health Access California
Health Equity Solutions
Healthy Illinois Campaign
Health Care For All Massachusetts
Maryland Health Care For All Coalition
Maine Consumers for Affordable Health Care
New Jersey Citizen Action
New Jersey Appleseed
New Mexico Center on Law and Poverty
Northwest Health Law Advocates
Pennsylvania Health Access Network
Shriver Center on Poverty Law
Take Action Minnesota
The Commonwealth Institute

Building on the ACA:
Lessons from the States

Community Catalyst, in coordination with the undersigned state consumer health advocacy organizations from across the country, has developed a list of priority actions for Congress and the Biden Administration that will:

1. Improve affordability and quality of coverage;
2. Expand access to comprehensive coverage; and
3. Strengthen existing programs to better serve consumers.

All of these priorities are guided by the underlying and urgent need to advance health justice and racial equity. Just as Black and brown people suffered increased COVID-19 illness and death, they also had higher uninsured rates prior to the pandemic. These communities have faced years of discrimination in employment and education and continue to face barriers to accessing the care they need. As a result, they are more likely to work in low-wage jobs without good benefits like health coverage. The Affordable Care Act and Medicaid are critical to helping people gain access to affordable coverage but more can be done to open up coverage opportunities, especially for those excluded from programs and resources; we have a clear moment of opportunity to strengthen the underlying policies of the ACA and Medicaid and reorient them toward racial justice and health equity.

This unique consortium of consumer health advocates represents states from across the country who have spent years investing in the success of the Affordable Care Act (ACA) and the Medicaid program in their respective states. They were the first to adopt state-based Marketplaces, embrace the goals of new coverage programs and continue to advance coverage and affordability work in their states when the work at the federal-level stalled. These states are laboratories for innovation in health care policy and, therefore, in addition to our priority actions for federal policymaking, we have highlighted examples from these states that can serve as models in health policy innovation as federal policymakers consider future reforms.

Improve affordability and quality of coverage

A significant barrier to health insurance coverage is lack of affordability. The ACA has made care more affordable (and therefore more accessible) for millions, but not all. Many who are eligible for subsidies are still uninsured due to affordability problems or enrollment barriers. The issue of unaffordable coverage disproportionately affects low-income people, especially people of color. In addition, the refusal of twelve states to expand Medicaid leaves millions without affordable coverage. According to a recent report from the Center on Budget and Policy Priorities, 2.2 million adults live without any realistic access to health care in states that have not expanded Medicaid, 60 percent of whom are people of color. As states committed to equity, we recognize closing the Medicaid coverage gap is an urgent issue of racial and health equity and support continued federal action to address the deep inequities that face people in non-expansion states. No one should live without access to health care.

All of these underlying barriers to coverage are only being exacerbated now as the country continues to fight against a global pandemic and the resulting financial crisis. The American Rescue Plan Act (ARPA) took significant steps toward improving affordability for consumers and should be made permanent. Additionally, we believe federal policymakers must consider the following:

- **Address the affordability of qualified health plans –** The passage of the ARPA takes us in the right direction. It provides two years of enhanced premium subsidies, making coverage more affordable for millions. Since passage, over one million people have taken advantage of the new subsidies and enrolled in Marketplace coverage. The ARPA enhancements are critical to help individuals and families' secure access to care during the pandemic and are a needed correction to the ACA subsidy scale and must be made permanent.

  We recommend that Congress make the ARPA provisions permanent including: 1) enhanced premium subsidies along a progressive sliding scale; 2) no premiums under 150 percent FPL and 3) caps on premium contributions to 8.5 percent of income.

  The work to address affordability must not stop at premiums. Federal policymakers should work to improve affordability of cost-sharing as well. While the ARPA provisions bring down premiums for all consumers through more generous subsidies, cost-sharing remains a barrier to accessing health services, particularly for low- and moderate-income people. Deductibles for Marketplace plans are very high: the medians for bronze, silver, and gold plans in 2021 are $6,921, $4,816, and $1,641, respectively. Specifically, it is important to note that because health care costs tend to grow faster than wages, people are getting less generous coverage each year relative to their income. This places a progressively greater affordability burden on lower income and sicker people. Congress has the opportunity to tackle both problems – make the premium subsidies permanent and reduce cost-sharing, making coverage affordable for millions of people.

  We recommend that Congress address the problem of high out-of-pocket costs by benchmarking premium subsidies to the "gold" metal level instead of the silver level, enhancing cost-sharing subsidies and extending them to consumers with incomes up to 400 percent FPL. In addition, cost sharing should not grow faster than CPI year over year. Together, a gold benchmark and enhanced cost-sharing subsidies would make the cost of care more affordable for all enrollees, but particularly for low- and moderate-income people eligible for plans with an actuarial value of 85 percent or more.

California and Massachusetts State Subsidy Programs

Massachusetts has the lowest uninsurance rate in the country at 2.9 percent, which has been the case since passage of their landmark health care law in 2006. While there are likely several contributing reasons, easily the most influential is the additional premium and cost-sharing subsidies provided in Massachusetts under Connector Care (previously Commonwealth Care). The program generously subsidizes coverage to enable $0 dollar plans, and very low premium plans for individuals under 300% FPL, while also subsidizing cost-sharing so that the plans have actuarial values well above 90%. Further, the only cost-sharing is in the form of copayments; there are not deductibles or co-insurance in Connector Care plans. The high take-up of coverage in MA can be linked to these more generous coverage options, as evidenced by a study from MIT and Harvard economists who found that every $40 a month decrease in premiums from subsidies increased enrollment by 14-24%.

Similarly, California took unprecedented action in 2019 to provide additional affordability assistance to nearly one million Californians enrolled in Covered California health plans. These new state subsidies augmented existing federal premium subsidies for Covered California enrollees with incomes between 200% to 400% FPL, along with first-in-the-nation premium assistance for middle-class consumers between 400% to 600% FPL. Simultaneously, the state implemented a penalty for failure to have qualifying health insurance and enhanced their outreach and marketing efforts amidst the pandemic and new COVID-19 special enrollment period. In 2020 CoveredCA reported a 40% increase in new enrollment attributed to the combination of these policy decisions. While this enrollment increase cannot be completely attributed to the enhanced subsidies, continuing to improve affordability, now in tandem with the federal subsidy enhancements, remains a priority as the cost of health coverage is still out of reach for too many California families already struggling to make ends meet in a high cost of living state.

Several states, including Maryland, Washington, New Jersey and Colorado, are following suit and implementing their own state-subsidy programs designed to reach the remaining uninsured and help consumers who are underinsured afford better coverage options. State interest and action to improve premiums and cost-sharing assistance is indicative of not only what people need most right now, but also an evidenced-based way to decrease uninsured rates and improve coverage retention. Congressional action to make the ARPA premium subsidy improvements permanent and to address cost-sharing would allow states to use their state dollars to fill any affordability gaps, offer even more significant financial assistance, or invest in coverage and affordability programs for populations not covered under the federal law.

- **Reduce barriers that keep individuals and families from enrolling in more affordable Marketplace coverage.** Currently, and estimated 4.8 million people who could benefit from more affordable coverage options through the ACA Marketplaces are currently locked out based on an affordability determination of their employer-sponsored coverage, also known as "the family glitch." An estimated 2.7 million uninsured people have incomes under 400 percent FPL, but cannot receive tax credits for Marketplace plans due to a "firewall" that applies to those with an offer of employer coverage. An estimated 710,000 low-and moderate-income workers enrolled in an employer plan considered "affordable" under the ACA pay about an average of $400 toward per person their premiums (after adjusting for the employer coverage tax treatment) as a share of income than they would if they enrolled in a Marketplace plan with tax credits. Families earning less than 200% of poverty would save $580 per person in premiums if the family glitch is eliminated -- and that doesn't include higher cost-sharing, since the family members would be eligible for cost-sharing reductions, and therefore higher cost of care. We recommend redefining this so-called firewall to be fairer to workers who would otherwise be locked into high-cost employer coverage.

Federal policymakers must eliminate the "family glitch." This could include an administrative fix that would allow spouses and dependents of an employee with an offer of affordable coverage to access tax credits when family coverage is unaffordable. Alternatively, through legislative action, federal policymakers could allow an entire family to enroll in Marketplace coverage with subsidies when employer coverage available to the family members is "unaffordable."

Congress should also redefine the test for affordable, adequate employer coverage so that it aligns with what workers would be expected to pay toward their premiums and out-of-pocket costs for Marketplace coverage based on their household income. That would mean, for example, that the "firewall" test for a family with income at 200 percent of poverty would require employer plan premiums be no greater than 2 percent of income in 2021 and 2022 (or 6.52 percent of income in 2023 and beyond) and the plan actuarial value to be 70 percent or more in order to bar workers and their families from accessing Marketplace subsidies.

Expand access to comprehensive coverage

There remains a significant opportunity federally to build on the foundation of the ACA to reach the remaining uninsured and advance on the path to universal coverage, particularly for people who have historically been left out of coverage options. As people lose their jobs, they lose their health insurance too – widening the coverage gap for people of color in this country. Even before COVID-19 hit, 29 million people in the U.S. lacked health insurance coverage, including a disproportionate share of people of color who face unjust and discriminatory barriers to health and economic security. The economic impact of the pandemic provides a backdrop for ever more urgency to expand access to comprehensive coverage now. The Administration's action to open HealthCare.gov has resulted in more than 1 million people signing up for coverage since February 12th, but more must be done to expand access to coverage. To achieve this goal, we believe federal policymakers should do the following:

- **Fully fund navigators, assisters and Consumer Assistance Programs (CAPs).** Even before the pandemic, signing up for the right health coverage for an individual or family was challenging – especially for people of color, people with disabilities, LGBTQ+ people, people for whom English is not the first language, and many others often have difficulty obtaining health care that meets their needs during the best of times. The ACA established in-person consumer assistance programs and funded navigators and assisters to help people in reviewing their coverage options and enrolling in coverage. Over the last four years, consumer assistance was undermined and unsupported for states not operating their own Marketplaces, leaving consumers with little if any support to navigate a highly complex process. As a result, enrollment in coverage programs declined across the country. The previous administration chose to invest in and promote direct enrollment and enhanced direct enrollment models allowing insurance companies and brokers (including web-based brokers) to enroll individuals in Marketplace coverage through their own websites, we strongly believe that web-based services cannot replace in-person enrollment and assistance. Reliance on these models exposes consumers to various risks including enrolling in subpar coverage that won't meet their needs.

According to recent data from the Assistant Secretary of Planning and Evaluation (ASPE), 11 million people are eligible but unenrolled in Marketplace coverage despite potentially being eligible for free or reduced-cost coverage. There is clearly more work to do in enrolling and securing health coverage for millions of people. CAPs, including navigators, are tools to drive equitable access to health coverage and create an at-the-ready infrastructure for health-related supports. Reinvesting in these programs should be the backbone to any federal plan to expand access to comprehensive coverage.

We recommend that Congress and the Administration work together to leverage unused Marketplace user fees to robustly fund Navigator programs and return Navigator grants to three-year grant cycles with a renewed focus on communities of color. We also recommend re-imagining their role to include a range of activities, including but not limited to, health literacy, vaccine education, data collection and care coordination. This issue is particularly important in driving equitable access for people for whom English is not their primary language, people with disabilities and other excluded people who are sidelined by the health system.

Additionally, we recommend that Congress restore and enhance funding for CAPs to provide year-round support to help consumers resolve medical bills, facilitate transitions between different forms of coverage and appeal coverage denials. The original amount of seed funding was $30 million for CAPs, we recommend that this be increased to $400 million annually for the next five years.

Maine, Massachusetts and New York Consumer Assistance Programs

Consumers for Affordable Health (CAHC) Care in Maine, Health Care for All (HCFA) and Health Law Advocates (HLA) in Massachusetts and Community Health Advocates (CHA) in New York offer three examples of Consumer Assistance Programs (CAPs) that continue to serve residents in their states today. While each program is unique in its design and how they reach community members, all three perform critical functions such as assist consumers with coverage rights, appeals and grievances, help consumers find the right coverage option, resolve billing issues and collect and track issues related to health insurance coverage experienced by consumers in the state to provide a feedback loop to decision makers and regulators.

Each program staffs a helpline that serves as a vital resource in assisting consumers across each state with the cultural and linguistic expertise needed to address health care issues facing diverse communities. In New York, CHA handled 32,932 cases across the state in 2020 fielding 6,953 calls through their central live-answer toll-free helpline. In Massachusetts, the HCFA HelpLine handles close to 20,000 calls a year. Similarly, CAHC delivers services statewide fielding over 8,000 calls through a HelpLine. The importance of these services was highlighted in 2020 as each state saw an increase in demand during the pandemic from consumers needing help with COVID-related medical care and bills and new coverage options due to lost employment. In Maine, for example, the HelpLine Advocates spent 85,749 minutes on the telephone with consumers and enrollment professionals in 2020, as compared to 66,046 minutes in 2019, a 30% increase reflecting the challenges presented during the pandemic. The need for consumer assistance demonstrated by these three states shows how critical these services are for consumers and the gaps in assistance that exist in the majority of the country where CAPs either no longer exist or operate with limited funding after federal funding was cut.

- **Streamline and reduce barriers to enrollment**. Individuals and families are eligible to sign up for comprehensive coverage when they become uninsured or when they experience other

circumstances, for example, a change in income that makes them eligible for premium subsidies. However, too few take advantage of those opportunities to enroll in coverage, either because they are unaware they are eligible to enroll or face barriers to enrollment. For example, when CMS imposed new requirements on applicants to document their special enrollment period (SEP) eligibility, SEP enrollment dropped compared to the prior year. State experience in Massachusetts actually suggests that making it easier for people to enroll in coverage, along with the state's more generous premium and cost-sharing support, increases enrollment, reduces the uninsured rate and doesn't cause significant adverse selection.

We recommend CMS streamline enrollment to use all available sources of data to confirm eligibility for coverage and financial assistance, requiring documentation only in cases where data is unavailable to the Marketplace as well as encourage states to extend open enrollment periods and SEPs more broadly.

We also recommend Congress look to successful state models, such as Maryland's Easy Enrollment program, to utilize federal tax forms and healthcare.gov to help identify and enroll uninsured tax filers, especially those who qualify for free and low-cost coverage. Underscoring the importance of these outreach initiatives, a recent study shows IRS outreach aimed at individuals who paid the tax penalty for failure to have minimum essential coverage led to an increase in coverage in subsequent years and a mortality reduction.

Maryland's Easy Enrollment Health Insurance Program

Maryland's Easy Enrollment Health Insurance Program has proven that agencies collaborating to streamline the enrollment experience can have a significant impact on coverage rates. The program was passed with bipartisan support in 2019. In the program's first year, 50,000 uninsured Marylanders checked a box on their state income taxes authorizing the Comptroller to share relevant information from their tax return with the state exchange for the purpose of eligibility determination and enrollment. The majority of those who enrolled through the program were children and young adults and virtually all were eligible for Medicaid or some federal subsidies, but had been previously unaware of their coverage options or how to enroll until they were contacted by the Exchange thanks to this program. Enrollment trends and focus group data affirmed the value of this approach. Maryland recently passed a law expanding the program to include a similar check-box for coverage on state unemployment claims, and other states like Colorado and New Jersey are looking to replicate this success with their Exchanges.

- **Extend postpartum coverage in Medicaid.** Racial inequities in maternal health have reached crisis proportions, with mortality for Black and Indigenous women nearly four times as high as for white women. Ensuring that all pregnant people have access to high-quality health care throughout the prenatal and postpartum period is a critical step towards ensuring that new mothers have access to health care when they need it most. While the American Rescue Plan Act provides a temporary option for states to extend the program to 12 months, it is insufficient. Without both a mandated benefit and additional financial support, we will not address the deep inequities that birthing people face, specifically Black women.

We recommend mandating a postpartum extension of Medicaid coverage from 60 days to a full 12 months and supporting states with 100% FMAP to extend the benefit as recommended by MACPAC in January of this year.

- **Expand access to coverage for populations who have historically been locked out.** All people should be able to get the health care they need, no matter their immigration status. Currently, there are unnecessary barriers for immigrants to access health coverage and care. The COVID-19 pandemic has laid bare the inequities people face in accessing good health, including policies designed to block immigrants from accessing health coverage and care. Immigrants are contributors to our communities, our neighbors and our family members. Immigrants are disproportionately low-income workers, women and uninsured. Congress has an opportunity to reverse these policies that bar people from good health and continue to fail our communities.

  We recommend that Congress take the following actions:

  - ***Restore enrollment to full-benefit Medicaid and the Children's Health Insurance Program (CHIP) to all federally authorized immigrants who are otherwise eligible.*** *As part of the Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA), legally residing immigrants were barred from accessing public benefits for five years, imposing an unfair waiting period. This discriminatory barrier to accessing needed care and other social supports has harmed too many for too long. Congress must eliminate the 5-year bar and ensure all individuals granted federally authorized presence, including Deferred Action for Childhood Arrivals (DACA) recipients, are eligible for federally funded health care programs.*

  - ***Provide undocumented immigrants access to health insurance coverage on the Affordable Care Act's Health Insurance Exchanges.*** *All people, regardless of status, should be eligible to purchase qualified health insurance coverage. In addition, all people should be able to access tax credits, cost sharing subsidies and the Basic Health Program regardless of their status. Congress should take steps to remove these barriers to accessing health coverage.*

  - ***Prioritize language access in outreach, enrollment and point of service****. Research shows that when people do not have high quality language access, they have worse health outcomes. Yet, when people have access to culturally competent care that includes high quality language access, their health outcomes improve. The research is clear that if we provided needed resources and training, we can improve people's health and build equitable systems of care. Currently, language access across health care systems is inconsistent—from outreach and enrollment to the doctor's office—leaving many individuals without the information they need to make health decisions. Congress must take steps to address language access by making sure all federal and state agencies are resourced to provide translation, interpretation services and additional resources are given to community-based organizations who are best positioned to support non-English speaking populations.*

- ***Support and fund a comprehensive outreach and education effort to combat fears and raise awareness about the rescission of the 2019 DHS public charge rule.*** *The Trump-era Department of Homeland Security (DHS) public charge rule was struck down by the Biden Administration in early 2020. But the climate of fear and misinformation continues to have a chilling impact on the use of public benefits--including COVID vaccines--by immigrants and their families. Congress has an opportunity to mitigate this chilling effect and help encourage immigrants and their families to utilize the health, food and other benefits to which they are entitled.*

  The chilling effect of the 2019 Public charge rule is still dampening enrollment into Medicaid and ACA coverage by individuals who are immigrants or who may live in mixed-immigration-status households. It would be incredibly impactful if HHS engaged in outreach and education about the public charge rule--especially when communicating with navigators and other enrollment assisters--that health coverage enrollment will not have any negative immigration consequences. It would be very helpful if HHS communicated this message to state Medicaid and insurance agencies as well and collaborated with those state agencies to provide simple messages that are tailored to the state's name for their Medicaid program(s) as well as for their marketplace.

Strengthen existing programs to better serve consumers

Existing federal waiver authorities as well as programs created under the ACA, such as the Basic Health Program (BHP), have been critical to state innovation and continued progress on coverage and affordability. Federal policymakers now have the opportunity to make further improvements to strengthen current BHP programs, create opportunities for further innovations, and encourage other states to adopt successful models like the BHP.

Minnesota and New York Basic Health Programs

Minnesota and New York both implemented BHP-funded programs in 2015 that successfully provide essential coverage to lower-income individuals and families with greater stability and affordability than QHPs on the Marketplace. MinnesotaCare provides affordable health coverage to 100,000 Minnesotans who earn less than 200 percent FPL (around $25,500 a year for an individual). The Essential Plan provides health coverage with no deductible and minimal cost-sharing to over 800,000 New Yorkers under 200% FPL.

We believe federal policymakers must do the following:

- **Revise the Basic Health Program (BHP) to provide states with greater flexibility and expanded coverage options.** Both New York and Minnesota have the opportunity to expand coverage through their BHP-funded programs, but face restrictions within the federal law for doing so. These opportunities to expand coverage would build on current BHP programs as well as expand BHP coverage options for other states. For example, advocates in New York would support a policy to cover pregnant women up to 233% FPL for the first year after pregnancy to avoid disruptions in

coverage. In Minnesota, advocates are supporting a proposal to allow individuals above 200% FPL to opt into MinnesotaCare coverage to gain more affordable coverage. Because federal funding for BHP is based on 95% of what would be paid in APTCs, raising or removing the income eligibility restrictions to cover higher income people would result in savings for the federal government, and thus be budget neutral. Similarly, providing greater flexibility for expanded coverage options to states with BHPs should include an option to let states use any extra BHP Trust Fund dollars to cover individuals regardless of immigration status.

Congress should permit coverage of eligible individuals regardless of immigration status as well as raise or remove the 200% FPL cap on BHP eligibility in order to allow states to expand coverage to populations above that income level--for example, 300% of FPL.

- **Clarify that states may consider the BHP part of the single risk pool**. As evidenced in Minnesota and New York, BHP is a proven policy option that is working to reduce costs for consumers, states and the federal government. However, some states that would otherwise like to explore BHP as a state option have avoided taking up the BHP because of the federal policy interpretation that the BHP must have a separate risk pool from the rest of the individual market. States like Washington have reported that this has been a barrier to adoption because of a perception that the BHP would remove a share of eligible individuals from the individual market, potentially destabilizing this market.

  Congress or CMS should resolve this issue by clarifying that states may consider the BHP part of the single risk pool. CMS should also issue guidance about how states can do so within the federal risk adjustment methodology. This flexibility combined with expanded coverage options in a BHP are critical to incentivizing more states to take advantage of this program.

  Congress should also make grants available to state-based marketplaces that need to modernize their systems to allow for inclusion of a BHP or other similar state programs.

- **Strengthen the BHP financial foundation.** Federal BHP funding decisions in the past few years have resulted in significant cuts to BHP states. We would urge federal policymakers to remedy past cuts, and strengthen BHP financing going forward. In particular, HHS should reverse the substantial cut to BHP funding to Minnesota that resulted from the partial approval of the state's 1332 reinsurance waiver.

  We urge the administration to review and improve the proposed 2022 BHP funding formula, both to remove harmful changes and to align the formula with the ARPA. At a minimum, we would urge HHS to remove the outdated Metal Tier Selection and Income Reconciliation Factors in revising the proposed 2022 BHP payment formula.

- **Improve the calculation of deficit neutrality for 1332 State Innovation Waivers.** The "deficit neutrality" guardrail for 1332 waivers requires states to demonstrate that proposed waiver programs do not increase the federal deficit. However, an overly narrow interpretation of this requirement has prevented states from pursuing innovative new models that would expand coverage, which is inconsistent with the original intent of this waiver program, the other guardrails in the statute, and the ACA more broadly.

We recommend that the administration reinterpret this provision to use of full enrollment as the "baseline" for estimating the impact on the federal budget and assessing "deficit neutrality." This alternate interpretation of "deficit neutrality" aligns with the aims of the ACA to expand coverage and would grant states the flexibility to create new waiver designs, including a state-level public option, to meet those goals.

- Encourage 1332 waivers beyond reinsurance. While we are encouraged to see significant federal legislative improvements to the cost of coverage this year, we also know that states will continue to play a vital role in moving the needle forward to improve the affordability of and access to comprehensive coverage. 1332 waivers provide a vehicle for more expansive state innovation that could, in turn, influence federal reforms in the future. So far, state innovation has been largely limited to reinsurance waivers. While these programs have helped states bring down premiums for certain consumers, the impact of the savings is limited to higher income earners. We think that the 1332 waiver has the potential to be a bigger catalyst for positive change.

  We encourage the administration to consider templates or models for 1332 waivers outside of reinsurance that could provide guidance and help streamline applications for states considering innovative state policies such as public options and other cost containment measures, as well as expanding coverage to populations currently locked out of coverage.

Community Catalyst

The Commonwealth Institute

Colorado Consumer Health Initiative

Community Service Society | Fighting Poverty Strengthening New York

Health Access

Health Care for All

Consumers for Affordable Health Care

Health Equity Solutions

Everthrive Illinois
Champions for Health Equity

HCFA Health Care For All Massachusetts

Healthy Illinois

Appleseed

Shriver Center on Poverty Law

New Jersey Citizen Action

NM center on law and poverty

Take Action MN

PHAN Pennsylvania Health Access Network