January 30, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 (CMS-9899-P)

Dear Secretary Becerra:

Thank you for the opportunity to submit comments on the Notice of Benefit and Payment Parameters for 2024 Proposed Rule, issued by the Department of Health and Human Services ("HHS" or the "Department").

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

We appreciate the administration's ongoing commitment to improving the accessibility, affordability, and adequacy of care for all patients and are confident the policies included in the proposed rule will advance these shared goals. We respectfully offer the following comments and recommendations addressing specific provisions of the proposed rule.

Standardized Plan Options and Limits on Non-Standard Plans

Standardized health plan designs offer numerous advantages to patients and consumers. Requiring plans to adhere to uniform cost-sharing parameters promotes informed decision-making: the shared standards reduce consumer confusion and make it easier to draw meaningful comparisons based on variables such as plans' premiums and network composition and design. Standardized plans can reduce cost barriers to care, by exempting services from the deductible and favoring copays (a consumer-friendly structure) instead of coinsurance. Moreover, standard plans can play a role in promoting health equity, by lowering cost barriers to services and supplies for health conditions that disproportionately affect people of color and others who historically have been underserved. For these reasons, we continue to support the Department's policy of requiring insurers on HealthCare.gov to offer plans with standardized cost-sharing parameters.

To maximize the consumer benefits of plan standardization, we strongly encourage HHS to finalize its proposal to limit the number of non-standard plans that insurers can offer. As you know, the number of plans available to consumers through the marketplace has increased dramatically over time, to the point where the sheer number of plan options now inhibits consumer decision-making. The proposed rule estimates shoppers for 2023 coverage were tasked with choosing among well over 100 plans, on average.[2] This environment favors the sophisticated insurers whose business it is to design health plans, at the expense of consumers who must expend limited time and resources to decipher among them. Indeed, as the proposed rule recognizes, research consistently shows that consumers confronted with too many health plan choices are more likely to make poor enrollment decisions or experience choice paralysis and forgo enrollment altogether.

A limit on the number of non-standardized plans would reduce the risks of choice overload while making it easier for consumers to make informed choices for themselves. We strongly believe that the Department's proposed limit is a commonsense fix for a real problem plaguing consumers, and it is one that can be implemented without risk to consumers or the market. Most states that require standardized plans also limit non-standard offerings to promote consumer decision-making.[3] And there

[1] Consensus Health Reform Principles. Available at: https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf.

[2] The proposed rule explains that the weighted average number of plans available per enrollee on HealthCare.gov for plan year 2023 was about 113.6.

[3] Giovannelli J, Schwab R, Lucia K. State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities. The Commonwealth Fund.

is no indication whatsoever that such limits have reduced competition, insurer participation, or plan innovation. The Department's proposed limit on non-standardized plans does not foreclose the ability of insurers to develop innovative plan designs; rather, it ensures that consumers will be better positioned than ever to determine whether such innovations offer unique value worth paying for.

Indeed, because the choice environment so favors insurers over consumers, we urge HHS to adopt *both* the proposed limit on the number of non-standard plans *and* a rule requiring an insurer's non-standard options to be meaningfully different from one another and from the standardized plan offering. It is hard to see any benefit to consumers of two near duplicate non-standard plan offerings (per insurer, per network type), or of a non-standard plan that has been crafted to deviate only slightly from the standard design. In both scenarios, similar but non-identical designs are likely to burden the shopping experience while failing to provide unique value for consumers. We believe a limit on non-standard plans and a meaningful difference standard are wholly compatible and should be adopted in tandem for 2024. In the event HHS determines to move forward with only one of these policies, we urge that it finalize the proposed limitation on the number of non-standardized plan options.

With respect to the design of the standardized plans themselves, we understand and appreciate the Department's desire to maintain continuity between the 2023 designs and those for 2024. Still, we encourage HHS to continue to look for ways to modify the standardized designs to reduce barriers to care posed by excessive cost-sharing. In particular, we urge the Department to consider expanding the services and treatments that are not subject to the deductible. We note that the standardized silver plan provides pre-deductible coverage of Tier 1 and Tier 2 prescription drugs, but requires consumers to spend through the deductible to access benefits at the higher drug tiers. However, state experiences with standardized silver plans suggest that that Tier 3 and specialty tier drug coverage can be provided pre-deductible within actuarial value and other common constraints. We ask that you adopt similar design approaches in the future.

We applaud the 2024 NBPP for requiring generics to be placed in the generic tier, or the specialty tier when appropriate (e.g. biosimilars), and brand name drugs in tiers 2, 3, or the specialty tier. For most patients, this will provide clarity on how the drug is covered. However, if a brand drug in a higher tier (i.e. tier 2, 3, or specialty) is cheaper than the generic, a patient should be able to access whichever drug is cheaper and pay the lesser amount.

Network Adequacy: Standards and Oversight

Federal law requires all marketplace health plans to maintain an adequate network of providers and an accurate and up-to-date online provider directory. These protections are designed to ensure that marketplace enrollees have timely, meaningful access to the care and services they need, as well as accurate information sufficient to enable them to understand plans' networks and identify the plans and providers most likely to meet their needs. They are vital to the patients and consumers we represent.

We thank the Department for adopting a rigorous, quantitative approach to evaluating network adequacy. We continue to support the requirement that marketplace plans satisfy time and distance standards for network sufficiency and strongly support the decision to implement appointment wait time standards for plan year 2024. We believe these new standards will add an important dimension to network adequacy review that is not captured by the 2023 framework.

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https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans. Published July 28, 2021.

We also strongly support the Department's commitment to ongoing and proactive oversight of plan networks. To that end, we urge HHS to test plans' compliance with the new appointment wait time standards during the year. To the extent plans are unable to comply with any of their network adequacy obligations and can provide adequate justification for their noncompliance (as permitted under federal rules), we ask that these justifications be made public in a timely manner.

As you consider how to improve network oversight further, we encourage the Department to scrutinize networks for their ability to provide culturally- and linguistically-competent care as well as physically and programmatically accessible care. This should include, among other things, a rigorous assessment of whether a network includes sufficient providers with appropriate language proficiencies, and/or provides sufficient access to appropriate language services, including ASL, to ensure individuals with limited English proficiency can obtain timely care in their preferred language, and a rigorous assessment of accessibility of provider offices and medical diagnostic equipment. It also means networks must be required to ensure access to culturally appropriate care that reflects the diversity of enrollees' backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, people with disabilities, and LGBTQI+ individuals.

Additionally, HHS should continue to strengthen standards for and oversight of marketplace plan provider directories. To enable consumers to identify the plans and providers likely to meet their needs, marketplace plans must be required to indicate in their provider directories the languages, other than English, which are spoken by a provider and/or their staff as well as the accessibility of the office. Plans' directories should also clearly specify the telehealth capabilities of participating providers. More should be done, proactively, to ensure directory information is reliable — a notorious, longstanding problem, as the Department well knows, and a particular concern for accessing mental health services.[4] Without accurate and up-to-date information regarding participating providers, it is impossible for consumers to make informed plan selections, no matter the help they receive from enrollment assisters or shopping support tools.

Network Adequacy: Applicability of Federal Standards

While a marketplace health plan that does not use a provider network is subject to the ACA's statutory requirements regarding enrollee access to providers (including essential community providers (ECPs)), it has been exempted from the network adequacy and ECP rules that implement these ACA protections. This arrangement invites no-network plans to ignore their statutory obligations and puts consumers at risk.

We support the Department's proposal to remove the exemption for plans without a network and require all marketplace plans to adhere to federal network adequacy and ECP regulatory standards. Requiring all plans to meet minimum regulatory requirements will facilitate consistent enforcement of the ACA's consumer protections throughout the market. We agree that this change will make it easier for consumers to compare their marketplace plan options and may reduce enrollees' exposure to high cost-sharing, all in furtherance of the goals of the statute.

[4] Katherine Ellison, "73 doctors and none available: How ghost networks hamper mental health care," Washington Post, Feb 19, 2022.

We thank the Department for its attention to this issue; however, there is more that should be done to ensure that the ACA's protections are consistently applied across the marketplaces. We have previously expressed concern that the standards and compliance regimes for ensuring marketplace network adequacy vary substantially across the states—this despite fact that marketplace network adequacy is a federal obligation. As we have said before, a marketplace consumer's ability to access an adequate network of providers should not depend on what state they live in. Therefore, we believe federal baseline quantitative standards should be extended to all marketplaces, federal and state-run alike. Just as with many other ACA consumer protections, states could retain flexibility to apply and enforce standards that are more stringent than the federal minimum. But marketplace issuers in all states should be accountable for ensuring their enrollees have an adequate network as promised by federal law.

Health Plan Marketing Names: Oversight and Standardization

HHS reports that there has been a significant increase in the number of plans sold through HealthCare.gov with marketing names that contain cost-sharing and benefit information. HHS and state insurance regulators have reviewed these names and have concluded that the information they convey is often incorrect or misleading. To address this problem, the Department proposes to adopt specific regulatory language requiring plan marketing names to include correct information, without omission of material fact, and to not be misleading, and to review plan marketing names during the annual plan certification process.

Our organizations have also observed an increase in the number of marketplace plans with lengthy marketing names, containing information with the potential to mislead or, at the least, to confuse consumers and make shopping for coverage more difficult. For example, we have seen many plan names that purport to describe applicable cost-sharing for certain benefits, or the applicable deductible, but that omit the context necessary for consumers to understand the actual cost-sharing features and limitations of the plan.

We appreciate the Department's attention to this growing problem and support the proposal, particularly the Department's commitment to reviewing all plan names during the certification process, in collaboration with its state counterparts. As regulators conduct these reviews, we urge that the focus be on ensuring that marketing names are accurate and succinct. While a common cause of confusion, as you know, is the absence of material information in a plan name, we suspect the best cure for this problem rarely will be for the plan name to become even longer and more detailed.

Indeed, we believe the best approach to these issues, to reduce confusion and aid consumer decision-making, is for the Department to establish a standardized format for marketing names. Standard names should include basic and limited information about that the plan, only: the insurer and metal level, and —potentially — a non-misleading identifier for the plan's network. All other plan features are immediately viewable on the plan preview display on HealthCare.gov, a click away on the plan details page, or in context within plan documents, and are extraneous to the name.

Navigators: Door-to-Door Enrollment Assistance

Navigators and other consumer assistance personnel play a vital role in educating the public about their coverage opportunities through the marketplaces and public programs, and assisting consumers with enrollment. The services provided by these individuals will be especially critical as the Medicaid continuous coverage requirement put in place at the outset of the public health emergency come to an end.

Under current rules, Navigators and other consumer assisters are permitted to make unsolicited door-to-door contacts to perform their outreach and educational functions, but may not do so to conduct enrollment assistance. The Department explains that this limitation was put in place, in the initial years of the marketplaces, as an extra safeguard for consumer privacy and security. The Department proposes to remove this blanket limitation because numerous other measures taken in the intervening years offer sufficient protection for consumers and because doing so will reduce barriers to enrollment assistance and coverage access.

We share the Department's commitment to reducing barriers to coverage access, which we believe is of particularly high priority in light of the forthcoming end of Medicaid continuous coverage. At the same time, we are cognizant that unsolicited contacts are, in fact, a longstanding method used to perpetrate frauds and other scams on consumers. If the Department finalizes its proposal, we strongly urge that it adopt additional, specific steps to minimize these risks. This certainly includes additional training for assisters and targeted outreach to the communities whose members will be solicited. It should also include requirements that permit consumers to readily verify the identity of the person(s) who has contacted them and to receive immediate documentation of the encounter, including contact information and instructions about how the consumer may cancel any enrollment that has occurred.

Navigators: Other Consumer-Focused Standards

We believe the Navigator program would be further strengthened were the Department to reinstate the remaining community- and consumer-focused program requirements that were eliminated when Navigator funding was scarce and establish additional standards to prevent the assister-consumer relationship from being undermined. In particular, we suggest that marketplaces again be required to have at least two Navigator entities, at least one of which must be community-based and consumer-focused, and have a physical presence in the marketplace's service area. We also request that Navigators be expressly prohibited from referring the individuals they serve to debt collection, conduct which is wholly afield from, and contrary to, their consumer assistance responsibilities

Web-broker Website Requirements and Standards for Agents, Brokers, and Web-brokers

The Department proposes several changes to facilitate and improve oversight of agents, brokers, and web-brokers. We support these measures. In our view, however, more action is needed. We recommend that HHS prohibit agents and brokers that sell marketplace plans from marketing products that are not compliant with the ACA's individual market reforms (such as short-term limited duration products) during marketplace open enrollment. The Department should also require brokers to act in the best interest of the individuals they serve, as consumers rely on them for their professional experience and expertise. Agents and brokers should also have an affirmative duty to screen consumers for Medicare and Medicaid eligibility, so that individuals who qualify for such coverage are not instead routed to private insurance products, as sometimes happens now. In addition, given the risks posed by their financial conflicts, agents and brokers should also be required to disclose the amount of their commissions.

Finally, HHS should consider establishing an assessment for direct enrollment and enhanced direct enrollment entities, to reflect the special benefits these entities derive from the ACA marketplace structure and regulatory framework. The funding generated from such an assessment could be reinvested in the marketplaces, to the benefit of stakeholders and consumers.

Annual Eligibility Redetermination, Re-enrollment Hierarchy

The Department proposes two changes to the annual re-enrollment hierarchy, the set of rules specifying how to enroll current marketplace enrollees who are eligible to remain in marketplace coverage in the coming year but who have not returned to the marketplace to shop actively during open enrollment. The first proposal would allow marketplaces to automatically re-enroll a current bronze plan enrollee who is eligible for cost-sharing reductions (CSRs) into a silver tier plan with CSRs, provided the new plan has a lower or equivalent premium (after accounting for subsidies) and is within the same product as their current plan. The second proposal would modify the hierarchy so that individuals automatically re-enrolled in new coverage are placed in a plan with a network most similar to the network used by their old plan.

We support these changes. With respect to the first proposal: we agree that allowing for automatic re-enrollment of CSR-eligible bronze enrollees into lower (or equivalent) premium silver plans will improve affordability for these individuals, in some instances, dramatically. We also understand the re-enrollment process, as described in the proposed rule, to be sufficiently protective of these individuals' coverage preferences, and to provide sufficient notice and opportunity for them to select an alternate plan, if they choose. With respect to the second proposal: we have urged HHS, in the past, to ensure that automatic re-enrollment rules minimize disruptions to an enrollee's network. Provider network changes can cause confusion and increase the risk of consumers delaying care or incurring out-of-network costs. We therefore appreciate and support the proposal to modify the re-enrollment hierarchy to preference plans with networks most similar to their current plan.

We also support, in principle, changes to the re-enrollment hierarchy that account for net premium and total out-of-pocket costs. With respect to net premium, for example, it is certainly the case that an automatic re-enrollment system that permits re-enrollment of individuals into a plan with zero net premium would, by reducing cost and administrative barriers, promote coverage retention. We emphasize, however, that while we believe incorporating net premium into the hierarchy is appropriate, it should not supersede other considerations and safeguards designed to reflect enrollee preferences and minimize disruption in care access.

Special Enrollment Periods: Medicaid

The Department proposes two changes to special enrollment period (SEP) policy that appear designed to reduce barriers to coverage, and the risk of coverage gaps, for individuals who will lose Medicaid during the upcoming unwinding of the Medicaid continuous coverage requirement.

First, HHS notes that current SEP rules do not allow new coverage to take effect mid-month or retroactively; instead, the new plan generally begins the first day of the month following loss of the old coverage. While this is not necessarily a problem when a consumer's old coverage ends at the end of a month, the proposed rule observes that some states regularly terminate Medicaid or CHIP coverage mid-month. To enable an individual facing a mid-month loss of coverage to transition immediately to a marketplace plan without a gap, the Department proposes to give marketplaces the option of greater flexibility over effective dates.

Second, HHS proposes to extend the special enrollment sign-up window for individuals losing Medicaid or CHIP from 60 days to 90 days, to provide these consumers more time to avail themselves of the opportunity to reestablish eligibility for public coverage and, if unsuccessful, still enroll in a marketplace plan.

We thank the Department for these thoughtful proposals and strongly agree with the justifications presented for adopting them. Separately from this proposed rule, CMS has announced a temporary Exceptional Circumstances SEP for those losing Medicaid or CHIP coverage due to the unwinding of the Medicaid continuous enrollment condition from March 31, 2023 to July 31, 2024 for Marketplaces using the Federal platform. We support this policy.

As the Department well knows, consumers who lose Medicaid during the unwinding may face numerous additional administrative hurdles beyond those that complicate transitions from the program in normal times. We believe these circumstances warrant affording consumers more time to understand and navigate their options.

Special Enrollment Periods: Mid-Year Changes to Plan Networks

HHS solicits comment about whether to provide an SEP to consumers whose providers leave their network mid-year. We support the addition of such an SEP. As we have discussed above, access to an adequate network is essential to the patients we represent, and network composition is therefore often a critical or deciding factor in plan selection. While an enrollee whose provider leaves the network mid-year may not always be well-served by using an SEP to switch plans — in part because out-of-pocket spending towards cost-sharing limits would reset — we strongly believe consumers in such a situation should have the option of reassessing the changed plan and choosing another. A consumer in this situation may, or may not, be protected by continuity of care provisions, state versions of which enable eligible enrollees to continue to access the now out-of-network provider for a limited period, at in-network cost-sharing rates. We urge HHS to consider adopting continuity of care requirements that provide similar protections. This, as the Department notes, is a protection that already exists in Medicare Advantage and we encourage HHS to provide the option for marketplace enrollees, too.

User Fee Rates for the 2024 Benefit Year

HHS proposes that the 2024 user fee rates for issuers that participate on the FFM or a state-based marketplace on the federal platform (SBM-FP) will be 2.5 percent and 2.0 percent, respectively. These rates are .25 percentage points lower than they were in 2022-2023 and, with respect to the FMM, substantially smaller than in all previous years of the program.[5]

We are grateful for the extensive efforts undertaken by the administration to support the work and purpose of the marketplaces. This includes substantially increasing spending on consumer outreach and education, following years in which funding for these vital responsibilities shriveled. As we have in the past, we urge HHS to maintain and expand these investments, and to consider devoting additional resources to improving the HealthCare.gov interface, which would benefit consumer decision-making and facilitate enrollment for health plans. To help sustain the progress of the marketplaces and support the record number of consumers now enrolled in coverage through the portals, we suggest that user fee rates be returned to pre-2022 levels.

Thank you for the opportunity to provide these comments. If you have any questions, contact Rachel Patterson at the Epilepsy Foundation at rpatterson@efa.org.

[5] The user fee rate for FFM issuers was 3.5 percent from 2014-2019 and 3.0 percent in 2020-2021. HHS did not charge a user fee for issuers on the SBM-FP until 2017. The fee rate for SBM-FP issuers was 1.5 percent in 2017; 2 percent in 2018; 3 percent in 2019; and 2.5 percent in 2020-2021.

Sincerely,

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American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Cancer*Care*
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Eczema Association
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