

PUBLIC SUBMISSION

As of: 1/28/23, 3:10 PM
Received: January 16, 2023
Status: Posted
Posted: January 27, 2023
Tracking No. lcz-ejrm-pf5k
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0011

Comment on CMS-2022-0192-0003

Submitter Information

Name: Joel Zimmerle

Email: jzimmerle@myhst.com

General Comment

I understand wanting to make sure clients are taken care of and in the right plan but making clients complete a form saying we are their agent is just another barrier that makes an already tough job even tougher and more inefficient. I understand there are some bad eggs in the U65 health insurance space but please don't use a broad brush and punish all those that are really out here just trying to help clients by adding additional barriers for them to get help.

A nice solution for this could be when we enroll a client on the marketplace, instead of sending them a bunch of emails about picking a plan, enrolling and paying (since we've already helped them with this), instead sending them an email/text that states that we are their agent and our NPN number. THIS I believe would stop a lot of the issues we see where clients are stolen from us by a few bad apples in the U65 space. So if some shady agent/broker tried to steal a client from me by enrolling them under their NPN this would send the client an email/text saying the agent name and they (the client) could see right there it is wrong because they know we are their agent and have a relationship with them. This would seem to be a better fix than adding another form for clients to complete.

Please consult with those of us that are in this business before applying a new regulation as we are the ones in the trenches so our feedback should be important.

Thank you!

PUBLIC SUBMISSION

As of: 1/28/23, 3:16 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Health Care Industry - PI015 Tracking No. ld4-oszf-5obf Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0014

Comment on CMS-2022-0192-0003

Submitter Information

Name: Yahoska Perez

Address:

MIAMI, FL, 33196

Email: yperez@healthexps.com

Phone: 7862027078

General Comment

I vote yes. We need documentation with client consent to avoid fraud that so many agents commit by stealing clients. Medicare doesn't have this type of issue.

PUBLIC SUBMISSION

As of: 1/28/23, 3:17 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Federal Government - G0005 Tracking No. ld4-plw2-jzkd Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0015

Comment on CMS-2022-0192-0003

Submitter Information

Name: Lynn Pokrifka

Address:

Jenkintown, PA, 19046

Email: LPokrifka@consultant.com

Phone: 2158859988

General Comment

I don't see how increasing the paperwork burden of agents helps with increasing access to health care services. Nearly all of my marketplace business is done by phone. Getting an additional signature requires a printer or smart phone, which most people who are underserved don't have. I am happy to assist anyone who calls me, regardless of the outcome being marketplace or Medicaid. Most people I speak with are grateful to have a broker to answer their questions.

Requiring additional documentation will hinder the process and I may decide to NOT do business on Healthcare.gov at all, thus having the opposite effect of the rule.

PUBLIC SUBMISSION

As of: 1/28/23, 3:21 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Federal Government - G0005
Tracking No. ld4-q2y8-3pvv
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0017

Comment on CMS-2022-0192-0003

Submitter Information

Name: Anonymous Anonymous

Email: jlinos@myeph.com

General Comment

HHS is continually creating uncompensated mandates for agents, brokers and web-brokers who are licensed, trained and certified to assist individuals in enrolling via the Marketplaces. We are already required as a part of the existing application to question and obtain the customer's consent to assist with completion of the Marketplace application and enrollment.

The continual burden of additional mandates for which we are not compensated for our time is working towards pushing agents, brokers and web-brokers out of assisting individuals and families from enrolling via the Marketplace. The loss of assistance from this large group of certified, licensed and trained individuals will be detrimental to the untrained public who generally tends to shop for health insurance based solely upon cost which I have seen again and again since the opening of the federal Marketplace. These price only based decisions tend to result in individuals facing very high out-of-pocket expenses for medical care and/or causes individuals to forego healthcare due to the cost of care.

This then leaves only navigators who are not licensed, certified or trained and by CMS regulations cannot make recommendations for individuals based upon their individual healthcare needs and budget. Navigators are only allowed to assist with application completion and plan enrollment. So this again leaves individuals and families again making enrollment decisions without the benefit of guidance from licensed, certified and trained individuals.

PUBLIC SUBMISSION

As of: 1/28/23, 3:22 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Private Industry - Health Care Tracking No. ld4-qsd9-zidn Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0019

Comment on CMS-2022-0192-0003

Submitter Information

Name: William LeGrand

Address:

Denver, NC, 28037

Email: WRLeGrand@gmail.com

Phone: 704-488-8363

General Comment

I greatly appreciate you taking the time and consideration of my viewpoints for the proposed consent rules for PY2024 in selecting Marketplace plans. I am an independent agent who has worked with customers since the very first year ACA plans were offered. My client base has grown over the years, and I estimate that I have assisted at least 3000 unique clients since the inception of the plan. I am greatly appreciative of the opportunity to help people in selecting their plans.

With that being said, I have a great deal of concern about the proposed consent rules and the burden it stands to place on Agents in assisting customers. My primary concern is the fact that I assist a large portion of clients via phone. Obviously, this is the preferred method for most people, given how busy people tend to be. Honestly, I feel that it is one of my strengths in that I am able to provide exceptional service in a manner that does not require the client to extenuate themselves in selecting their coverage.

The second element, which ties directly into the above reason, is cost. For those clients that we do not meet with face-to-face, we are going to have a very difficult time getting an affordable and efficient means of recording the consent. Programs to record the calls or have a document e-signed are quite expensive. They also tend to be cumbersome.

Lastly, and probably most importantly, will be the element of time. I am fortunate to have a favorable number of customers that I assist. It is also a burden in some senses as well, because I have a relatively short window (45 days) to help each and every one of them. It is a difficult and arduous enough task as things stand now. I honestly feel that with these new provisions and processes it may make it difficult to

assist both my current clients and obtain the new clients that the insurers require for me to get to keep my contract(s). My main goal is to make sure that every person I have helped the year before gets their plan for the following year (if they need it). I am genuinely concerned I will spend more time "getting consent" than actually servicing the customer(s).

I completely understand the reasoning for these proposed changes and rules. However, in some ways I feel like this is the case of a few "bad apples" spoiling things for those of us who act appropriately in helping clients every year. I will do my very best and follow all rules, whatever is decided/finalized. I just wanted to provide a little prospective from the "ground floor" to let you know some of the practical issues this is going to provide to many agents. I think everyone will adapt as needed, but it puts Independent Agents, like myself, in a slightly precarious situation.

Feel free to contact me directly in any further input is needed! I appreciate the forum and have a great day!

William "Ryan" LeGrand
704-488-8363

PUBLIC SUBMISSION

As of: 1/28/23, 3:24 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Government - G0001
Tracking No. ld4-r5n1-xi2b
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0020

Comment on CMS-2022-0192-0003

Submitter Information

Name: Arthur Rosen

Address:

Denver, CO, 80224

Email: artrosen@gmail.com

Phone: 3038724937

General Comment

CMS file code CMS-9899-P.

Sirs,

These are add-ons that will slow an already cumbersome process, notwithstanding the annual technical issues that cause problems for clients and Brokers.

Attestation that an individual does NOT want to be screened for financials.

This should not be required. Clients who do not want financial assistance still receive the benefits when they file their taxes. This is an add-on that is not necessary.

Attestation of Financial Review signed by client before submission of an application.

Again, this is redundant as the individual is reconciled when they file taxes. Easy solution is to send a client a financial summary by the Exchange to confirm their numbers after the application is submitted. Corrections can be made at that time by the client and subsequently the application.

Alternative example:

Dear Client, Please review for accuracy the following financial information from your recent application. If there is a discrepancy, please make the required adjustments through your Broker, or directly using your Healthcare.gov account.

Arthur Rosen

--

Arthur Rosen

NPN 1170408

303-872-4937

PUBLIC SUBMISSION

As of: 1/28/23, 3:26 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Government - Federal
Tracking No. ld4-rk89-zpvp
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0021

Comment on CMS-2022-0192-0003

Submitter Information

Email: jeff@juenemanninsurance.com

Organization: Juenemann Ins Agency

General Comment

My comment relates to the 2024 Model Consent Rule.

Asking to get consent forms signed in advance to collect, quote, advise, submit or service customers is one more step in making a complicated process harder. I am an independent insurance agent in Michigan. Many of my customers find me through the MarketPlace agent directory. (I'm not soliciting them) Or they are current Property and Casualty clients. If you want to make this a requirement for Multi-State agent, for agencies with more than 10 or 50 representatives, navigators, etc. because of past complaints, then this is a good idea. But to include individual agents, who have been involved with MP products for 10 years, who have no complaints, have established relationships with current customers is excessive and burdensome.

Jeffrey G Juenemann, CPCU

NPI 987743

33652 Ford Rd

Westland, MI 48185

734 261-5010

PUBLIC SUBMISSION

As of: 1/28/23, 3:27 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Health Plan or Association Tracking No. ld4-rtqa-xe59 Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0022

Comment on CMS-2022-0192-0003

Submitter Information

Name: Anonymous Anonymous

General Comment

I am opposed to the new rules. Looking at the new rules as a consumer, it feels as if you think I am attempting to be deceptive and need to be policed/investigated by agents/brokers. The plans are already expensive, with massively high deductibles, with minimal coverage, and now you want to "watch over" my information that I consent to be truthfully submitting. I could see if you were giving these plans out for free.

PUBLIC SUBMISSION

As of: 1/28/23, 3:28 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Health Care Professional/Association - Other Health Care Professional
Tracking No. ld4-rxiu-hfpu
Comments Due: February 13, 2023
Submission Type: Web

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0023

Comment on CMS-2022-0192-0003

Submitter Information

Name: Josh Carr

Address:

OH,

Email: carrasquillojosh@gmail.com

General Comment

"Further, we propose to require agents, brokers, or web-brokers assisting consumers with completing eligibility applications through the FFEs and SBE-FPs or assisting an individual with applying for APTC and CSRs for QHPs to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative prior to application submission. We propose that the documentation would be required to include: the date the information was reviewed; the name of the consumer or their authorized representative; an explanation of the attestations at the end of the eligibility application; and the name of the assisting agent, broker, or web-broker. Furthermore, the documentation would be required to be maintained by the agent, broker, or web-broker for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement activities." This will slow down the amount of clients one can help, it also will be additional redundant barriers for agents and enrollees. Many clients renew each year by phone and only clear why for them to review is with their own eyes.

"We also propose to require agents, brokers, or web-brokers assisting consumers with applying and enrolling through FFEs and SBE-FPs, making updates to an existing application, or assisting an individual with applying for APTC and CSRs for QHPs to document the receipt of consent from the consumer or their authorized representative seeking assistance prior to providing assistance, which would include the consumer taking an action that produces a record of consent and the maintenance of that record by the agent, broker, or web-broker. We also propose standards for the content of the documentation of consent, including that it would be required to include a description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative, the date consent was given, name of the consumer or their authorized representative, and the name of the agent, broker, web-broker, or agency being granted consent, as well as the process by which the consumer or their authorized representative may rescind consent. Further, we propose that agents, brokers, or web-brokers would be required to maintain the consent documentation for a minimum of 10 years and produced upon request in response to monitoring, audit, and enforcement

activities." This too will create barriers for consumers looking for insurance or wanting to make updates. No one wants to make changes just to create work. Requiring all this stuff will create scenarios of consumers not updating info because it has become too much hassle. We have many clients who don't use email, some don't have cell phones so to create a method to authenticate an agent will drive those consumers away.

"Second, we propose to change the current coverage effective date requirements at § 155.420(b)(2)(iv) to permit Exchanges to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC. These changes would ensure qualifying individuals are able to seamlessly transition from other forms of coverage to Exchange coverage as quickly as possible with minimal coverage gaps" This is needed for those employers who end coverage on last day of employment. Clients often have a gap in coverage because the current rules of a first of month start date.

If the new rules are going to require the level of consent being asked, two things need to happen: 1. a standardized document/electronic tool available. 2. this documentation should also be sufficient to send to the marketplace for agents to act on their behalf. There is no reason to require agents to jump through these hoops to then do it again if a call to the marketplace is needed. There needs one seamless process to cover both the agent and marketplace needs. I read comments about agents complaining who was the agent of record, if they don't have the minimum information or willingness to reach out to the client they are not the agent. Furthermore, if the lengths of consent are needed, carriers should not be able to hold consumers under previous upline if a renewal has been completed (Ambetter policy when changing appointment).

Need more rules around re-enrollment, if someone turns 26 and it will change based on proposal at the end of that year. The system should not automatically re-enroll in self plan. Matter fact the re-enrollment/auto renew needs some work. Carriers should not be able to send any information/billing etc until several days past 12/15. Many consumers who wait till the last minute get duplicate information and mass confusion what plan they have and the cost. It is also havoc for agents looking in their carrier portals to see 2 and 3 line items for policies.

PUBLIC SUBMISSION

As of: 1/28/23, 3:33 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Government - Federal
Tracking No. ld4-szmw-v357
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0024

Comment on CMS-2022-0192-0003

Submitter Information

Name: Anonymous Anonymous

General Comment

Having a consumer sign an additional document for consent to begin a health insurance application during an already small open enrollment window is just going to make it much more difficult to assist individuals with enrollments in a timely manner. If the application is read verbally on a recorded line, that should be enough to consider consent. As it currently stands, the consumer is already required to provide consent when the agent reads the consent disclosure. Why add an additional separate document? This rudimentary consent form will only hinder renewals and new enrollments in 2024. Focus on making the enrollment process faster not longer.

PUBLIC SUBMISSION

As of: 1/28/23, 3:34 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Tracking No. ld4-tcyl-kf4e
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0025

Comment on CMS-2022-0192-0003

Submitter Information

Name: Constance Brown

Address:

Morrow, GA, 30260

Email: constance_brown@bellsouth.net

Phone: 4045455360

General Comment

I suggest that each client should be given a PIN # to provide to the Broker at the time of enrollment. This will cutback on paperwork and time providing and getting the information to and from the client. This will protect the client and the broker.

I was told that IRS has a program whereas the taxpayers is given a PIN # to prevent fraud. See if IRS program can work for the Healthcare.gov program. For new enrollees a PIN # can be issued at the time the broker enrolls them.

PUBLIC SUBMISSION

As of: 1/28/23, 3:41 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Other - OT001
Tracking No. ld4-vu8m-44iu
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0029

Comment on CMS-2022-0192-0003

Submitter Information

Name: Theresa Renee Brown

Address:

Palm Harbor, FL, 34685

Email: renee.brown@healthmarkets.com

Phone: 7276000850

General Comment

I understand that there are some irreputable agents that mess things up for those of us that are trying to do the right thing to help as many people as we can in and out of open enrollment. What you are not seeing is that the individual insurance is not paying us enough to have cause us to want to have to take even more time with each of these people doing all the back and forth documentation just to prove we are the agent of record and that we are doing our job to the best of our ability with the information given to us by the client.

With open enrollment and AEP for Medicare running together most agents are more into assisting the senior population and not concerned with the under 65 book of business. We have to sell as much Medicare as possible to make enough money to run several months with very little pay from health carriers. I know I have a rather large book of business on the under 65 group but if forced to having to spend more time with them on things that are not helping either myself or my clients, I will be forced to cut that part of my business down to a bare minimum of people. Unfortunately my under 65 group also helps me obtain clients I can take on into Medicare as they turn 65 so I will be forced to work harder to come up with more clients.

For the agents like myself that have never had a complaint against them nor been discharge from the marketplace for wrong doing, why are we being basically punished for doing right. My customers trust me and most of them have been my clients for several years, and that should show the value agents like myself are. Even though I do not get paid a lot on this book of business, I am continually assisting my clients with uploading documents and updating income. I take pride in my work and in the fact that my

customers know they can rely on me. I do not like the thoughts of giving all that up, but like everyone else I have to be able to make the money during AEP to last me awhile. Putting these rules and regulations on us is just going to take up a lot more of time we do not have, so please reconsider and look at it from our perspective as to how little time we have during AEP/OEP to make money and do our best to help as many people as we possibly can, which for most of us means very little sleep and no family time or anything else time from October 1st to Dec 15th.

PUBLIC SUBMISSION

As of: 1/28/23, 3:42 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Private Industry - Health Care Tracking No. ld4-w7pt-a195 Comments Due: February 13, 2023 Submission Type: Web

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0030

Comment on CMS-2022-0192-0003

Submitter Information

Name: Anonymous Anonymous

Email: alexgarcia911@hotmail.com

General Comment

As it is trying to get people to understand and enroll into a health insurance plan is very difficult. Many enrollees are low income and have very little computer access. An additional form will be a burden for people with little to no access to computers, and mailing forms will also be costly for them. I believe that this new requirement will limit and lower the amount of people enrolling for health insurance in the future.

PUBLIC SUBMISSION

As of: 1/28/23, 3:43 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Tracking No. 1d4-wd3t-if3d
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0031

Comment on CMS-2022-0192-0003

Submitter Information

Name: Ettie Gorecki

Address:

Salt Lake City, UT, 84109

Phone: 801.831.6185

General Comment

As agents, we already document this information in our CRM. This is similar to the Medicare Scope of Appointment form. Instead of helping the client, it causes more red tape and ultimately a delay in their obtaining coverage in a timely manner. Please reconsider this rule.

PUBLIC SUBMISSION

As of: 1/28/23, 3:44 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Health Plan or Association Tracking No. ld4-x102-zir7 Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0032

Comment on CMS-2022-0192-0003

Submitter Information

Email: rjonas@dayinsurancewi.com

Organization: Day Insurance

General Comment

We are an insurance agency in a small town that assist's consumers in enrolling into the Marketplace. Consumers frequently come to us after dealing with either navigators or the Marketplace directly because they have a difficult time understanding how the Marketplace works over the phone, or because navigators can't recommend an appropriate plan for them.

Due to agent commissions being included in administrative costs outside of the Medical Loss Ratio, insurance carriers have cut them down to the point that it is not profitable anymore for agents to work with consumers on enrolling them into the Marketplace. Any additional burden placed on agents will only make this situation worse.

If the Marketplace wants to put additional administration requirements onto agents, my suggestion would be to then allow insurance companies to pay agents outside of the administrative costs of the MLR, thus ensuring fair compensation, and encouraging more agents to continue providing valuable services to an underserved population.

PUBLIC SUBMISSION

As of: 1/28/23, 3:45 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Category: Government - Federal
Tracking No. ld4-ykdw-3qgn
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0033

Comment on CMS-2022-0192-0003

Submitter Information

Name: Michael Kaplan

Address:

South Berwick, ME, 03908

Email: Michael@Tri-StateInsurance.net

Phone: 207-752-7373

General Comment

My only comment is that I have an issue with CMS making blanket policies because of the few bad apples. Please stop punishing the agents that are trying to do the right thing. You are costing us money, making our jobs more difficult, and as a result, are losing some good agents. Please direct your policies to the bad apples.

Example: CMS is costing me money as I now have to record all my calls, yet in 15 years, I have not had any complaints.

Having to record calls should be the end result of a complaint, not a blanket policy. (

Sincerely,

Michael D. Kaplan

Cell: 207-752-7373 (Recorded line.)

PS: It is my understanding that policies, such as recording calls, is a result of all the deceptive advertising. Why not make changes to the advertising guidelines, or better yet, stop the advertising all together. It is confusing the Medicare eligibles. CMS should be the only one advertising the enrollment periods.

PUBLIC SUBMISSION

As of: 1/28/23, 3:46 PM Received: January 20, 2023 Status: Posted Posted: January 27, 2023 Category: Health Care Industry - PI015 Tracking No. ld4-ytfg-l71o Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0034

Comment on CMS-2022-0192-0003

Submitter Information

Name: Lindsey Neumann

Address:

Saratoga Springs, UT, 84045

Email: lindseyn2021@gmail.com

Phone: 8016520280

General Comment

CMS-9899-P . Requiring extra signed authorizations from the consumer regarding consent is completely unnecessary, consumers don't want this and agents don't need it. We already document all of the things on these forms in our agency management system. With technology we are able to attach emails, text messages, and voicemails as well as notes of our own. All of this documentation as well as the actual signed policy document provides more than enough documentation to validate the client's authorization . As agents, we already are struggling to assist our entire book of business (not including referrals and new business) in the SHORT time period we have been given during OEP...that is also already during the BUSIEST TIME OF YEAR for everyone agents and clients alike. This is unnecessary and a waste of everyone's time and resources.

PUBLIC SUBMISSION

As of: 1/28/23, 3:48 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Tracking No. 1d5-1db6-dfue
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0036

Comment on CMS-2022-0192-0003

Submitter Information

Name: Jonathan Tate

Email: jtate@ventureinsgrp.com

Phone: 8103386433

General Comment

Regarding Burden Hours listed in Table 2 of the Supporting Statement for Agent/Broker Consent Information Collection (CMS-10840/OMB control number: 0938-XXXX)

The Burden Hours listed per applicant is .08 (4.8 minutes). The .08 estimate is radically low. Consider the time it takes to produce the document edited with the client's particular information (6 lines) and send the document for electronic signature (docusign or similar). Then consider the time it takes for people with LEP, people without electronic means to sign, and people who are not technologically literate. We do the same thing with the scope of appointment and applications for Medicare. Between preparing and sending the forms, then following up with phone calls to walk the client through how to sign them, we budget 30 minutes. The real world takes 6 times more than what you have budgeted on paper.

Rather than requiring one more unnecessary paper to get in the way, just make the carriers add the verbiage to each of their applications. Require agents to either get a signed application or a recorded phone call.

PUBLIC SUBMISSION

As of: 1/28/23, 3:50 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Tracking No. 1d5-26ji-sueb
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0037

Comment on CMS-2022-0192-0003

Submitter Information

Name: Anonymous Anonymous

General Comment

CMS

Are we really having an issue with licensed agents enrolling people with marketplace plans without their knowledge or consent? Or is this just one more regulation to cripple our industry in terms of time and making consumers feel like we are not credible.

I understand the CMS SOA for Medicare because we are dealing with some people whose cognition maybe in decline. Also understand due to the over advertising of Medicare Advantage plans and their misleading offers.

Under 65 market is not that way and certainly can make their own healthcare decisions by speaking with licensed agents, that they agree to speak with to help them. Requiring more documentation to be kept for 10 years is not necessary and a burden.

If you are having a problem with marketing, advertising and any type of fraud why don't you go after the companies creating the problems rather than penalize all of the hard working agents. We are asked to do almost the impossible of enrolling the entire country in complicated, expensive health insurance in 6 weeks with an extension of 6 weeks for those that start Feb. 1. We offer help to consumers for the tax credits and are always there for questions thru the year.

Please do not put this extra burden on our country's licensed insurance agents. If you want it to apply to non licensed agents, that might be fitting. But please denote the difference and do not penalize licensed agents.

PUBLIC SUBMISSION

As of: 1/28/23, 3:50 PM
Received: January 20, 2023
Status: Posted
Posted: January 27, 2023
Tracking No. 1d5-52zm-129p
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0038

Comment on CMS-2022-0192-0003

Submitter Information

Name: Courtney Callaway

Address:

Omaha, NE, 68134

Email: courtney@primechoiceins.com

General Comment

Document Citation: 87 FR 78206

Page: 78206-78322 (117 pages)

CFR:

45 CFR 153

45 CFR 155

45 CFR 156

Agency/Docket Number: CMS-9899-P

RIN: 0938-AU97

Document Number: 2022-27206

Comment:

The best way to understand the value of additional regulation (that ethical agents are likely the only ones to follow) is to show the reasoning behind the new regulation. And the reason is not apparent here.

These proposed guidelines are typically put in place to prevent bad actors. So my initial question is, what is the plan for this documentation? Will agents/brokers be required to submit these signed documents to the Marketplace for every customer before we can earn our commission? Or will agents be required to

save copies in-house in the event they are asked to show proof of documentation after the fact? If the signed documents are only provided upon request, how does that additional documentation help CMS at that time? I presume agents must provide this documentation when consumer complaints occur. And at that point, what does the additional documentation allow CMS to do that they cannot do already?

All of this to say, these additional steps are being asked of agents to what end? What is the benefit?

Will agents be required to obtain this documentation every single year from every single customer?

Ref: 2022-27206 CMS Comment Period related to:

CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great state(s) ~~TX~~ **M** *Please explain your operation and why you are important to your clients.*

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
- Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FFs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)**

- I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

- **Section 155.220(j)(2)(ii)(A)(1)**

- To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- I am concerned with the words, "under penalty of perjury." I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
- I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- Please keep in mind, many consumers do not have access to computers, most have access to phones.
- With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

- **Section 155.220(j)(2)(ii)(B)**

- This section is speaking about an issue that is happening across the nation to many professionals.
- I know colleagues who have had a "rouge" agent steal their clients.
- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
- When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,



TAI CHIN

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great state(s) **XXXX**. ***Please explain your operation and why you are important to your clients.***

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
- Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FFs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)**
 - I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
 - I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
 - An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information
- **Section 155.220(j)(2)(ii)(A)(1)**
 - To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
 - I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
 - I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
 - Please keep in mind, many consumers do not have access to computers, most have access to phones.
 - With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.
- **Section 155.220(j)(2)(ii)(B)**
 - This section is speaking about an issue that is happening across the nation to many professionals.
 - I know colleagues who have had a “rouge” agent steal their clients.
 - Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
 - This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
 - Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
 - When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
 - Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
 - We need help in this area but requiring additional paperwork doesn’t seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great state(s) **XXXX**. ***Please explain your operation and why you are important to your clients.***

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
- Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FFs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)**
 - I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
 - I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
 - An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information
- **Section 155.220(j)(2)(ii)(A)(1)**
 - To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
 - I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
 - I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
 - Please keep in mind, many consumers do not have access to computers, most have access to phones.
 - With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.
- **Section 155.220(j)(2)(ii)(B)**
 - This section is speaking about an issue that is happening across the nation to many professionals.
 - I know colleagues who have had a “rouge” agent steal their clients.
 - Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
 - This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
 - Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
 - When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
 - Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
 - We need help in this area but requiring additional paperwork doesn’t seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Ref: 2022-27206 CMS Comment Period related to:

CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great state(s) XXXX. ***Please explain your operation and why you are important to your clients.***

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
- Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FEs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)**

- I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)(1)**

- To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- I am concerned with the words, "under penalty of perjury." I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions Insurance and personally and professionally hold myself to the highest regard of integrity.
- I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- Please keep in mind, many consumers do not have access to computers, most have access to phones.
- With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

- **Section 155.220(j)(2)(ii)(B)**

- This section is speaking about an issue that is happening across the nation to many professionals.
- I know colleagues who have had a "rouge" agent steal their clients.
- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
- When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

JOSE MARTINEZ



Jan. 30, 2023

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

www.securityhealth.org

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

Security Health Plan of Wisconsin, Inc., appreciates the opportunity to submit recommendations in response to the proposed HHS Notice of Benefit and Payment Parameters for 2024 to support enhanced consumer experience and greater competition and efficiency in the marketplace.

Headquartered in central Wisconsin and serving 225,000 members in all 72 Wisconsin counties, Security Health Plan is the 5th largest health plan by membership and 6th largest by premium volume in Wisconsin. The health plan is part of the Marshfield Clinic Health System.

Security is a not-for-profit health plan with coverage for large and small employers, individuals and families through the Federally-facilitated Exchange, Medicare and Medicaid beneficiaries, plus benefit administration for self-funded employers. Security has been certified as a Qualified Health Plan every year since the Health Insurance Marketplace was launched in 2013.

Security Health Plan supports efforts to ensure a highly functioning and stable individual and small group market, expanding consumer access to high quality, affordable coverage and care. Consumers deserve to be well informed on a broad choice of options available to them. We support the proposals that will ensure consumers have enhanced opportunities to enroll in coverage and avoid losing coverage when the public health emergency ends. We favor proposed changes that advance health equity by addressing health disparities and also offer the following considerations for CMS.

Part 153 - Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Data collection proposals

Security Health Plan feels proposals requiring the collection and extraction of Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator will present significant complications. We currently receive HRA information from our small groups. We recommend that the proposed rule engage in discussion with carriers and employers on the best way to capture this information before finalizing this provision for 2024. Additionally, we would like more information on what system would this QSEHRA indicator be extracted from to be sent to CMS.

Discontinue Lifelong Permanent Conditional List and Use of Non-EDGE Claims

Security Health Plan supports retaining both the lifelong conditions list and the use of non-EDGE claims.

- Providers often include lifelong conditions in a “medical history” list, as these conditions are monitored but in some cases not actively managed if the patient’s condition is stable. Even though they are listed in “medical history,” they are lifelong conditions that never go away.
- If the use of non-EDGE claims were to be discontinued, there may be times that some conditions would not be validated. This could result in a loss of Hierarchical Condition Category codes getting validated during the Risk Adjustment Data Validation process.

In the zero-sum arrangement, we perceive that discontinuing lifelong conditions and use of non-EDGE claims wouldn’t impact our results in terms of falling outside acceptable fail rate parameters and incurring negative risk transfers.

HHS-RADV Discrepancy and Administrative Appeals Process

Security Health Plan has no concerns with shortening the time period.

Termination of coverage or enrollment for qualified individuals (§ 156.270)

Security Health Plan has no concerns if another letter is not being proposed as we have this process in place. Today we send a premium statement that indicates delinquency when a member has missed a monthly payment. If the member has APTC and is delinquent we also send a concurrent letter advising the member of the amount due. We do not have comment on a timeliness standard.

Network Adequacy (§ 156.230)

Security Health Plan has concerns with the Appointment Wait Time Standard proposal. We urge CMS to revise requirements for health insurers to attest to provider wait times, something the insurer does not have control over. We’re concerned that if providers don’t meet the standard, it will be held against the issuer. Especially in rural areas that make up a large portion of our service area, appointment wait times often change daily, making it difficult to obtain accurate measurement from providers. Health plan monitoring and enforcing contracted provider conduct presents significant operational challenges, especially as the public health emergency nears its end and we face significant provider shortages.

Further, we request that CMS continue to allow for appropriate exceptions to the network adequacy standards implemented last year for the individual market, realizing the difficulty in constructing adequate networks for plans serving rural communities such as ours. We are committed to ensuring access to appropriate providers, but must work in challenging environments where recruiting and retaining providers is a challenge and the time and distance individuals travel are longer than their urban counterparts. Specifically, we urge you to allow for family medicine providers to count toward requirements for pediatric providers. And, additionally, allow for flexibility when it comes to fulfilling requirements for certain specialty providers in the time and distance standards due to the remote geography of some rural communities and the reality of the economics of specialty care in rural areas.

Like our members, Security Health Plan is frustrated by variations in wait times but is not able to fix them without a dedicated national solution requiring providers to self-report. We request CMS grant leniency regarding appointment wait time provisions that are poised for implementation in 2024 until a national solution is introduced.

Essential Community Providers (§ 156.235)

Security Health Plan supports the Agency's efforts to increase consumer access to providers to advance health equity through the inclusion of two new Essential Community Providers categories, 1) Mental Health Facilities/Substance Use Disorder Treatment Center; and 2) Rural Emergency Hospitals added as a provider type "Other." However, we feel establishing categorical thresholds may lead to inflexibility and does not account for regional variation. We request CMS continue to explore the implications this proposal would have for access and availability for issuers in rural service areas.

We are also concerned regarding the timeframe of when provider lists are released so issuers are abreast of which facilities are considered ECPs in these categories. We recommend that CMS work with issuers to obtain additional perspectives on network adequacy and the unique issues they face with respect to provider availability, especially in rural areas.

Standardized Plan Options (§ 156.201)

Security Health Plan recommends CMS remove the proposal to limit the number of non-standardized plan options health issuers can offer on the Marketplace. In order to assuage consumers who may feel overwhelmed by the plethora of options, the 2023 final rule required all issuers to add standardized options to their offerings at every metal level, rating area and within every network design. Contrary to its intent, however, the provision in the 2024 proposed rule to limit non-standardized plan options would increase consumer confusion regarding plan selection. If health plans reduce their product offerings, many consumers may end up enrolled in plans they did not choose because they will need to be cross walked to new plans.

We feel the proposed notice would impose a significant burden on issuers and could result in fewer narrow network plans. This would negatively affect member retention, as consumers rely on the pricing relief offered by narrow networks.

In addition, Security Health Plan has concerns with the specific approach to tiering for standardized plan options within the prescription drug template. While we appreciate CMS' intent to give consumers a more intuitive pricing structure for generic prescription drugs, "generic" does not always equal the lowest cost drug. Our formulary generally places lower cost generic brands in tier 1 and more expensive generics in tier 2. Not all generic drugs are cost-effective, and uniformly moving them to a single generic cost-sharing tier would increase costs for beneficiaries overall as it could result in higher premiums. This could cause significant disruption if proposals to limit the number of non-standardized plans are adopted.

Part 156 – Meaningful Difference Standard

Security Health Plan recommends CMS finalize proposals to introduce a meaningful difference standard as an alternative to limiting non-standardized plan options. Establishing a meaningful

difference standard would achieve the intent to enhance the plan selection experience by giving consumers an enhanced ability to make better, informed choices. To better support this proposal, we recommend a difference of \$500 in deductible, as opposed to the proposed \$1,000 difference, as a more feasible strategy.

Ability of states to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs (§ 155.220)

Before providing a comment, Security Health Plan would request more specifics on the new proposed procedures and additional consumer protection standards for agents, brokers, and web-brokers that assist consumers with enrollments through FFEs.

Providing Correct Information to the FFEs (§ 155.220(j))

Security Health Plan does not have a comment on a specific method but will note that larger agencies would be better equipped for this than small independent agencies. This is directly aligned with the current Medicare documentation requirement of 10 years.

Re-Enrollment Hierarchies

Security Health Plan recommends CMS revise or delay proposals for automated processes for re-enrollment of coverage. We acknowledge the need to help consumers find the most cost-effective plan choice, but caution against overriding consumer choice. Annually we roll out a robust communication plan to assist consumers to opt into the most appropriate coverage for their needs. Automated processes may lead to unintended consequences. We request CMS take further consideration into all the reasons enrollees may have for choosing a particular plan. Overriding an enrollee's chosen plan may cause member confusion and affect overall retention.

Conclusion

Security Health Plan appreciates the opportunity to comment and provide recommendations on these important policies for consumers and issuers for the plan year 2024. We welcome additional opportunities to engage with the Administration to ensure a robust and competitive individual market that provides coverage options for all, especially as we near the expiration of the public health emergency. Please contact me with any questions or to discuss these recommendations further.

Regards,



Krista Hoglund, ASA, MAAA
Chief Executive Officer
Security Health Plan of Wisconsin, Inc.
hoglund.krista@securityhealth.org
715-221-9485

Jan. 30, 2023

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

www.securityhealth.org

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

Security Health Plan of Wisconsin, Inc., appreciates the opportunity to submit recommendations in response to the proposed HHS Notice of Benefit and Payment Parameters for 2024 to support enhanced consumer experience and greater competition and efficiency in the marketplace.

Headquartered in central Wisconsin and serving 225,000 members in all 72 Wisconsin counties, Security Health Plan is the 5th largest health plan by membership and 6th largest by premium volume in Wisconsin. The health plan is part of the Marshfield Clinic Health System.

Security is a not-for-profit health plan with coverage for large and small employers, individuals and families through the Federally-facilitated Exchange, Medicare and Medicaid beneficiaries, plus benefit administration for self-funded employers. Security has been certified as a Qualified Health Plan every year since the Health Insurance Marketplace was launched in 2013.

Security Health Plan supports efforts to ensure a highly functioning and stable individual and small group market, expanding consumer access to high quality, affordable coverage and care. Consumers deserve to be well informed on a broad choice of options available to them. We support the proposals that will ensure consumers have enhanced opportunities to enroll in coverage and avoid losing coverage when the public health emergency ends. We favor proposed changes that advance health equity by addressing health disparities and also offer the following considerations for CMS.

Part 153 - Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Data collection proposals

Security Health Plan feels proposals requiring the collection and extraction of Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator will present significant complications. We currently receive HRA information from our small groups. We recommend that the proposed rule engage in discussion with carriers and employers on the best way to capture this information before finalizing this provision for 2024. Additionally, we would like more information on what system would this QSEHRA indicator be extracted from to be sent to CMS.

Discontinue Lifelong Permanent Conditional List and Use of Non-EDGE Claims

Security Health Plan supports retaining both the lifelong conditions list and the use of non-EDGE claims.

- Providers often include lifelong conditions in a “medical history” list, as these conditions are monitored but in some cases not actively managed if the patient’s condition is stable. Even though they are listed in “medical history,” they are lifelong conditions that never go away.
- If the use of non-EDGE claims were to be discontinued, there may be times that some conditions would not be validated. This could result in a loss of Hierarchical Condition Category codes getting validated during the Risk Adjustment Data Validation process.

In the zero-sum arrangement, we perceive that discontinuing lifelong conditions and use of non-EDGE claims wouldn’t impact our results in terms of falling outside acceptable fail rate parameters and incurring negative risk transfers.

HHS-RADV Discrepancy and Administrative Appeals Process

Security Health Plan has no concerns with shortening the time period.

Termination of coverage or enrollment for qualified individuals (§ 156.270)

Security Health Plan has no concerns if another letter is not being proposed as we have this process in place. Today we send a premium statement that indicates delinquency when a member has missed a monthly payment. If the member has APTC and is delinquent we also send a concurrent letter advising the member of the amount due. We do not have comment on a timeliness standard.

Network Adequacy (§ 156.230)

Security Health Plan has concerns with the Appointment Wait Time Standard proposal. We urge CMS to revise requirements for health insurers to attest to provider wait times, something the insurer does not have control over. We’re concerned that if providers don’t meet the standard, it will be held against the issuer. Especially in rural areas that make up a large portion of our service area, appointment wait times often change daily, making it difficult to obtain accurate measurement from providers. Health plan monitoring and enforcing contracted provider conduct presents significant operational challenges, especially as the public health emergency nears its end and we face significant provider shortages.

Further, we request that CMS continue to allow for appropriate exceptions to the network adequacy standards implemented last year for the individual market, realizing the difficulty in constructing adequate networks for plans serving rural communities such as ours. We are committed to ensuring access to appropriate providers, but must work in challenging environments where recruiting and retaining providers is a challenge and the time and distance individuals travel are longer than their urban counterparts. Specifically, we urge you to allow for family medicine providers to count toward requirements for pediatric providers. And, additionally, allow for flexibility when it comes to fulfilling requirements for certain specialty providers in the time and distance standards due to the remote geography of some rural communities and the reality of the economics of specialty care in rural areas.

Like our members, Security Health Plan is frustrated by variations in wait times but is not able to fix them without a dedicated national solution requiring providers to self-report. We request CMS grant leniency regarding appointment wait time provisions that are poised for implementation in 2024 until a national solution is introduced.

Essential Community Providers (§ 156.235)

Security Health Plan supports the Agency's efforts to increase consumer access to providers to advance health equity through the inclusion of two new Essential Community Providers categories, 1) Mental Health Facilities/Substance Use Disorder Treatment Center; and 2) Rural Emergency Hospitals added as a provider type "Other." However, we feel establishing categorical thresholds may lead to inflexibility and does not account for regional variation. We request CMS continue to explore the implications this proposal would have for access and availability for issuers in rural service areas.

We are also concerned regarding the timeframe of when provider lists are released so issuers are abreast of which facilities are considered ECPs in these categories. We recommend that CMS work with issuers to obtain additional perspectives on network adequacy and the unique issues they face with respect to provider availability, especially in rural areas.

Standardized Plan Options (§ 156.201)

Security Health Plan recommends CMS remove the proposal to limit the number of non-standardized plan options health issuers can offer on the Marketplace. In order to assuage consumers who may feel overwhelmed by the plethora of options, the 2023 final rule required all issuers to add standardized options to their offerings at every metal level, rating area and within every network design. Contrary to its intent, however, the provision in the 2024 proposed rule to limit non-standardized plan options would increase consumer confusion regarding plan selection. If health plans reduce their product offerings, many consumers may end up enrolled in plans they did not choose because they will need to be cross walked to new plans.

We feel the proposed notice would impose a significant burden on issuers and could result in fewer narrow network plans. This would negatively affect member retention, as consumers rely on the pricing relief offered by narrow networks.

In addition, Security Health Plan has concerns with the specific approach to tiering for standardized plan options within the prescription drug template. While we appreciate CMS' intent to give consumers a more intuitive pricing structure for generic prescription drugs, "generic" does not always equal the lowest cost drug. Our formulary generally places lower cost generic brands in tier 1 and more expensive generics in tier 2. Not all generic drugs are cost-effective, and uniformly moving them to a single generic cost-sharing tier would increase costs for beneficiaries overall as it could result in higher premiums. This could cause significant disruption if proposals to limit the number of non-standardized plans are adopted.

Part 156 – Meaningful Difference Standard

Security Health Plan recommends CMS finalize proposals to introduce a meaningful difference standard as an alternative to limiting non-standardized plan options. Establishing a meaningful

difference standard would achieve the intent to enhance the plan selection experience by giving consumers an enhanced ability to make better, informed choices. To better support this proposal, we recommend a difference of \$500 in deductible, as opposed to the proposed \$1,000 difference, as a more feasible strategy.

Ability of states to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs (§ 155.220)

Before providing a comment, Security Health Plan would request more specifics on the new proposed procedures and additional consumer protection standards for agents, brokers, and web-brokers that assist consumers with enrollments through FFEs.

Providing Correct Information to the FFEs (§ 155.220(j))

Security Health Plan does not have a comment on a specific method but will note that larger agencies would be better equipped for this than small independent agencies. This is directly aligned with the current Medicare documentation requirement of 10 years.

Re-Enrollment Hierarchies

Security Health Plan recommends CMS revise or delay proposals for automated processes for re-enrollment of coverage. We acknowledge the need to help consumers find the most cost-effective plan choice, but caution against overriding consumer choice. Annually we roll out a robust communication plan to assist consumers to opt into the most appropriate coverage for their needs. Automated processes may lead to unintended consequences. We request CMS take further consideration into all the reasons enrollees may have for choosing a particular plan. Overriding an enrollee's chosen plan may cause member confusion and affect overall retention.

Conclusion

Security Health Plan appreciates the opportunity to comment and provide recommendations on these important policies for consumers and issuers for the plan year 2024. We welcome additional opportunities to engage with the Administration to ensure a robust and competitive individual market that provides coverage options for all, especially as we near the expiration of the public health emergency. Please contact me with any questions or to discuss these recommendations further.

Regards,



Krista Hoglund, ASA, MAAA
Chief Executive Officer
Security Health Plan of Wisconsin, Inc.
hoglund.krista@securityhealth.org
715-221-9485



December 27th, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

I am writing to you to publicly comment on the proposed changes to existing compliance rules for agents/agencies in DHHS Centers for Medicare & Medicaid Services 45 CFR Parts 153, 155, and 156 [CMS-9899-P] RIN 0938-AU97 Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, specifically section IV F-J relating to proposed changes to § 155.220(j).

I am an independent health broker/agent and I have worked with Marketplace customers since 2014. I started this agency specifically to assist with the new Marketplace options. I came from government disability services, and I understood all too well how disabled folks were unable to get insurance before ACA. Now, I run our health insurance brokerage of three total agents, and we assist (in addition to other lines) with individual insurance lines. Our agency is small and only serves one state. We are hyper-focused and know the plans very well and provide claims help all year to our customers.

I believe these 2024 proposed changes are highly duplicative and no more than expensive and unnecessary security theater. We already have a rule about documenting consent, which already duplicates state and federal laws on consent. People willing to commit already-illegal fraud will not be deterred by additional administrative burdens. I have no issue with documenting consent as currently required, in many ways this protects agents most of all. My issue lies in the administrative costs imposed on agencies in the 2024 proposal that is costly, uncompensated, and already is covered by existing laws.

Whether or not CMS intends to eliminate local agents by pricing them out so only the mega agencies with lobbying power remain, these types of administrative burdens will have that effect. In both the short and long term it is the American people who will suffer most. Our customers know us, they can find us at our office, and we are here to help them all year. I can contact internal insurance company reps who can help solve problems. We attend yearly trainings, we know about doctors and prescriptions and how claims go. Yet, we appear to be the enemy to regulators rather than your allies.

CMS has imposed many administrative and storage challenges over the years that cost small agencies a lot of money unnecessarily. This 2024 proposed rule seeks to apply the misguided CMS Medicare call recording and storage requirement. The Medicare call rule was imposed on

Wisconsin Health Insurance Advocate, LLC
9618 W Greenfield Ave
West Allis, WI 53214

Phone: 414-797-3408
www.wihia.com



WISCONSIN HEALTH Insurance Advocate, LLC

us earlier this year and was both incredibly expensive to implement and creates a constant expense that comes out of our meager pockets. It was an absolute scramble to find a compliant system. The big call centers already had such requirements so the costs were exclusive to small agencies offering local help. I estimate the total cost of purchasing a system to record, paying for staff time to maintain those files, and paying for an also mandated encrypted system will cost our agency \$10,000 a year, which is our entire profit margin. I don't mean my profit as the owner, I mean total agency profit that would have otherwise been used for staff raises and new equipment.

With the cost of inflation and decreasing insurance commissions this puts us in an impossible situation. There seems to be a perception at CMS that local agents are getting rich and taking advantage of people. On high end, an ACA policy in Wisconsin pays \$240 a year if the member stays enrolled all 12 months. Most are closer to \$100 a year for potentially multiple hours of skilled, highly trained work, and many are completely uncompensated. Most agents will then only cherry pick plans for folks. That's not how we operate.

There are many solutions to these significant system-wide problems that I am happy to discuss at another time. Today I am writing to you about the impossible situation small local brokers are put in. In my opinion, CMS has been targeting the wrong actors with policies such as the proposed one. These CMS policies have no effect whatsoever on the fraud being committed by people who are willing to break existing law. It is unnecessary to duplicate existing laws, and unfair to create additional administrative requirements without compensation on the professionals who are already complying with existing laws and regulations.

Rules and regulations should be simple, common sense, not create undue burden especially on small businesses, and they should allow for easy access to quality help for all Americans. I ask you to please consider valuing local help beyond a simple search site, we are the ACA allies and champions. Please do not add more duplicative administrative burdens and costs to local agents. I understand your goal is to stop bad actors, but these regulations only price out the good actors who care about ethics and compliance already. Once we are gone because we cannot yoke the costs, only the bad ones will be left.

Thank you for your consideration of this important matter.

Sincerely,

Sadie Tuescher
Owner

Wisconsin Health Insurance Advocate, LLC
9618 W Greenfield Ave
West Allis, WI 53214

Phone: 414-797-3408
www.wihia.com

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great state(s) **XXXX**. ***Please explain your operation and why you are important to your clients.***

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
- Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FFs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)**
 - I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
 - I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
 - An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information
- **Section 155.220(j)(2)(ii)(A)(1)**
 - To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
 - I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
 - I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
 - Please keep in mind, many consumers do not have access to computers, most have access to phones.
 - With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.
- **Section 155.220(j)(2)(ii)(B)**
 - This section is speaking about an issue that is happening across the nation to many professionals.
 - I know colleagues who have had a “rouge” agent steal their clients.
 - Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
 - This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
 - Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
 - When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
 - Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
 - We need help in this area but requiring additional paperwork doesn’t seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX OK FL NC SC GA OH MI TN MS KS. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of

income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
- O The Federal Marketplace is connected to the IRS, which should/could help in providing

correct income information.

- O The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. o The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
- O If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
- O I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

- O I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- O I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- O An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

- O To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- O I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
- O I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- O Please keep in mind, many consumers do not have access to computers, most have access to phones.
- O With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

- O This section is speaking about an issue that is happening across the nation to many professionals.
- O I know colleagues who have had a “rouge” agent steal their clients.
- O Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- O This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Kimberly D Lee Bay

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX OK FL NC SC GA OH MI TN MS KS. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you

risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

• I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

• Providing Correct Information to the FFs (Section 155.220 (j))

O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.

O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.

O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.

O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.

O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.

O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

• **Section 155.220 (j)(2)**

O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.

O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.

O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

• **Section 155.220(j)(2)(ii)**

O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.

O The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.

O The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. o The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We

are not considered our clients legal counsel and can only input the information we are provided.

O If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.

O I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.

O I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

O I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.

O I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.

O An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

O To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.

O I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.

O I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.

O Please keep in mind, many consumers do not have access to computers, most have access to phones.

O With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

O This section is speaking about an issue that is happening across the nation to many professionals.

O I know colleagues who have had a “rouge” agent steal their clients.

O Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.

O This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.

O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?

O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.

O We need help in this area but requiring additional paperwork doesn’t seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Christina Nguyen

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of FL GA IL IN ME MO NM NY OK TN TX WA WI. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.

- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.

- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.

- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.

- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.

- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.

- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.

- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.

- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess"

regarding income. This “guess” can be complex for the self-employed consumers.

- The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.

- The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. ○ The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.

- If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.

- I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.

- I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• Section 155.220(j)(2)(ii)(A)

- I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.

- I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.

- An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• Section 155.220(j)(2)(ii)(A)(1)

- To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.

- I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.

- I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.

- Please keep in mind, many consumers do not have access to computers, most have access to phones.

- With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• Section 155.220(j)(2)(ii)(B)

- This section is speaking about an issue that is happening across the nation to many professionals.

- I know colleagues who have had a “rouge” agent steal their clients.

- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.

- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.

- O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Stephanie Juarez

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX OK FL NC SC GA OH MI TN MS KS. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of

income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
- O The Federal Marketplace is connected to the IRS, which should/could help in providing

correct income information.

- The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. ○ The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
- If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
- I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
- I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

- I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

- To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
- I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- Please keep in mind, many consumers do not have access to computers, most have access to phones.
- With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

- This section is speaking about an issue that is happening across the nation to many professionals.
- I know colleagues who have had a “rouge” agent steal their clients.
- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Terese Y. McLachlan

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX IL MI OH IN and AR. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of

income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.

- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.

- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.

- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.

- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.

- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.

- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.

- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.

- O The Federal Marketplace is connected to the IRS, which should/could help in providing

correct income information.

O The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. o The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.

O If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.

O I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.

O I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

O I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.

O I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.

O An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

O To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.

O I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professional hold myself to the highest regard of integrity. O I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed. O Please

keep in mind, many consumers do not have access to computers, most have access to phones.

O With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

O This section is speaking about an issue that is happening across the nation to many professionals.

O I know colleagues who have had a “rouge” agent steal their clients.

O Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.

O This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.

O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

O When CMS and the web-brokers send an email asking folks to pick a plan (when they have

absolutely picked a plan already), they can add is John Doe your agent?

O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.

O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Afnan Adam

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P

P.O. Box 8016

Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX OK TN NC SC MI TN MS LA. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of

income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
- O The Federal Marketplace is connected to the IRS, which should/could help in providing

correct income information.

- O The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. o The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
- O If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
- O I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

- O I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- O I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- O An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

- O To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- O I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
- O I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- O Please keep in mind, many consumers do not have access to computers, most have access to phones.
- O With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

- O This section is speaking about an issue that is happening across the nation to many professionals.
- O I know colleagues who have had a “rouge” agent steal their clients.
- O Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- O This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Jared Nohr



January 24, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

I am writing on behalf of the Mid-Atlantic Association of Community Health Centers (MACHC), the federally designated Primary Care Association for Federally Qualified Health Centers (FQHCs) in Maryland and Delaware. Health centers provide a range of medical and support services, including prenatal care, dental care, pharmacy, medication-assisted treatment, behavioral health services, and other enabling services that facilitate access to care. With a steadfast presence in communities most in need, FQHCs have been on the front lines of the most pressing public health issues, including COVID-19, behavioral health, maternal health, and more.

MACHC advocates for health centers and the communities they serve. The association facilitates partnerships between health centers and stakeholders, including other healthcare providers, state governments, educational institutions, and community organizations, to advance their collective mission.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. In Delaware FQHCs, 38% of patients are Medicaid beneficiaries and 24% are covered by private insurance, while in Maryland 48% of patients are Medicaid beneficiaries and 22% receive private insurance. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, FQHCs help thousands of individuals seeking coverage each year. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. OUR ORGANIZATION strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed

changes in the proposed rule “Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

MACHC welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus comments on areas most important to FQHCs. MACHC’s comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

MACHC supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. MACHC recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, MACHC recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As OUR ORGANIZATION has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. MACHC recommends CMS enforce this

¹ Section 1311(c)(1)(C)

requirement given the statutory language. Currently, CMS mandates that QHPs on FFM must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, MACHC believes that these good-faith contracts should extend to all FQHCs in their service area.

MACHC recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least the PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders to engage with states and hold them accountable. MACHC recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

MACHC strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. MACHC appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. MACHC appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

MACHC also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person.>

⁶ [https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1\).](https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1).)

towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

MACHC also appreciates CMS’ proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

MACHC appreciates the Administration’s continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally Facilitated Marketplace.⁸ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as “billable providers” and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

MACHC is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, MACHC suggests they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. MACHC also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

MACHC supports CMS’ proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers’ interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

MACHC supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, MACHC applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and MACHC also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. MACHC appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

MACHC also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OUR ORGANIZATION appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

MACHC recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection MACHC supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years.

Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact me at dmcgonegal@machc.com

Sincerely,

A handwritten signature in cursive script that reads "Delaney McGonegal".

Delaney McGonegal

Director, Health Policy & Analytics

Mid-Atlantic Association of Community Health Centers



January 25, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

OACHC supports all of Ohio's 57 Federally Qualified Health Centers and FQHC Look-Alikes (more commonly referred to as Community Health Centers or CHCs), providing care to nearly 900,000 Ohioans across 485+ sites throughout 75 of the 88 counties. For 55+ years, CHCs have provided integrated whole person care, often providing medical, dental, behavioral health, pharmacy, vision, and other needed supplemental services under one roof.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, Ohio's FQHCs helped individuals seeking coverage. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. OACHC strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

OACHC welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

OACHC supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. OACHC recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, OACHC recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As OACHC has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. OACHC recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFM must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, OACHC believes that these good-faith contracts should extend to all FQHCs in their service area.

OACHC recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like OACHC, to engage with states and hold them accountable. OACHC recommends CMS

¹ Section 1311(c)(1)(C)

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ Section 1902(bb) of the Social Security Act

create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

OACHC strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)—to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. OACHC appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee’s residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

or live in rural area where it can be difficult to solicit enrollment assistance. OACHC appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

OACHC also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

OACHC also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

OACHC appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ Funding for this workforce is so important for health centers and the patients served. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person>.

⁶ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1>).

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

OACHC is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, OACHC recommends they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. OACHC also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

OACHC supports CMS’ proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers’ interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

OACHC supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

Similarly, OACHC applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and OACHC also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. OACHC appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

OACHC also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OACHC appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

OACHC recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection OACHC supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide

comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Julie DiRossi-King at jdirossi@ohiochc.org or (614) 884-3101.

Sincerely,

A handwritten signature in cursive script that reads "Randy Runyon". The signature is written in dark ink and is positioned above the printed name.

Randy Runyon

President & CEO

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX OK FL NC SC GA OH MI TN MS KS. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of

income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
- O The Federal Marketplace is connected to the IRS, which should/could help in providing

correct income information.

- O The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. o The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
- O If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
- O I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

- O I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- O I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- O An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

- O To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- O I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professional hold myself to the highest regard of integrity.
- O I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- O Please keep in mind, many consumers do not have access to computers, most have access to phones.
- O With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

- O This section is speaking about an issue that is happening across the nation to many professionals.
- O I know colleagues who have had a “rouge” agent steal their clients.
- O Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- O This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

David Cory Crawford

January 25, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

RIN 0938-AU97

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

Dear Administrator Brooks-LaSure:

On behalf of the nearly 40,000 members of the American College of Emergency Physicians (ACEP), we appreciate the opportunity to comment on the “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024” proposed rule.

Our comments are reflective of the proposals that have a significant impact on our emergency physician members and the patients we serve.

Network Adequacy and Essential Community Providers

ACEP supports CMS’ revisions to the network adequacy and essential community provider (ECP) standards, particularly to establish two new ECP categories starting in 2024: mental health facilities and substance use disorder treatment centers. ACEP has long advocated for strong network adequacy standards across CMS programs. For example, in 2020, CMS issued a rule¹ that codified many of its existing Medicare Advantage network adequacy requirements—including formalizing the list of specialty types that are included in the time and distance standards. When that 2020 rule was first proposed, ACEP [specifically requested](#) that emergency medicine be added to the list. We stated that we believe that it is essential for all beneficiaries enrolled in Medicare Advantage to know from their Medicare Advantage health plan in advance of an emergency if the emergency physician treating them is in-network (NOT during or after an emergency has occurred). The very nature of ED care, more than any other type of specialty care, precludes the opportunity for patients to preferentially go to facilities with in-network emergency physicians. CMS ultimately did not adopt our recommendation to add emergency medicine as a specialty type in its Medicare Advantage network adequacy requirements.

WASHINGTON, DC OFFICE

901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

BOARD OF DIRECTORS

Christopher S. Kang, MD, FACEP
President
Aisha T. Terry, MD, MPH, FACEP
President-Elect
L. Anthony Cirillo, MD, FACEP
Chair of the Board
John T. Finnell, MD, MSc, FACEP
Vice President
James L. Shoemaker, Jr., MD, FACEP
Secretary-Treasurer
Gillian R. Schmitz, MD, FACEP
Immediate Past President
Jeffrey M. Goodloe, MD, FACEP
Alison J. Haddock, MD, FACEP
Gabor D. Kelen, MD, FACEP
Rami R. Khoury, MD, FACEP
Heidi C. Knowles, MD, FACEP
Kristin B. McCabe-Kline, MD, FACEP
Ryan A. Stanton, MD, FACEP

COUNCIL OFFICERS

Kelly Gray-Eurom, MD, MMM, FACEP
Speaker
Melissa W. Costello, MD, FACEP
Vice Speaker

EXECUTIVE DIRECTOR

Susan E. Sedory, MA, CAE

¹ 85 FR. 33796. (June 2, 2020).

However, we were extremely pleased that CMS decided to add emergency physicians to the provider specialty list for time and distance standards for federal facilitated exchange (FFE) qualified health plans (QHPs) in the 2023 Notice of Benefit and Payment Parameters Final Rule.² Similar to the impact we believe such a policy would have on the Medicare Advantage population, we feel that this was an important step in helping to improve access to in-network emergency care for QHP enrollees.

CMS should continue to add more provider types to their network adequacy requirements and boost enforcement. Strong enforcement of network adequacy standards is crucial to ensure their execution. Creating these standards without proper enforcement would definitely undermine their overall effectiveness. As such, we seek further clarification on what penalties would exist for organizations that are non-compliant with these new standards.

Making It Easier to Enroll in Coverage

ACEP strongly supports CMS' proposal to allow for there to be special enrollment periods for individuals who lose their Medicaid and CHIP coverage to help mitigate coverage gaps. We are concerned that millions of Medicaid enrollees may lose their coverage once states begin with their redeterminations later this year. Continued, uninterrupted access to health insurance through enrollment in the Marketplaces would likely result in better health and health outcomes both for affected individuals as well as others in our country. As emergency physicians, we see every day the positive effect that insurance coverage has on our patients and their overall health—and this correlation is supported by a plethora of research. The Kaiser Family Foundation found in a 2019 study that one in five uninsured adults went without needed care in the previous year because of cost, as opposed to eight percent of publicly insured adults. Further, nineteen percent of uninsured adults said they delayed or did not get a needed prescription drug due to cost.³

Losing health care coverage hampers the financial stability of families and creates a burden to receiving necessary care. When people become uninsured, they may delay or avoid seeking vital care. Deferring or delaying care will often result in the exacerbation of a person's condition or symptoms, and eventually result in a trip to the emergency department (ED). At this point, due to the progression of their condition, the person's care in the ED will be much costlier and more complex than if he or she had earlier access to more routine care in a physician's office. An increase in the uninsured percentage leads to an overall worsening of health outcomes, including increased prevalence of obesity and malnutrition and reduced prescription adherence. It also affects patients' "social determinates of health," leading to increased rates of poverty and housing instability and reduced productivity and educational attainment.

If finalized, these provisions may also help maintain the financial viability of the emergency care safety net. Emergency physicians proudly serve as the country's safety net, treating all patients regardless of their insurance status or ability to pay. As a result of this vital role that we play, we incur unique financial risks, which include higher rates of uncompensated care than other clinicians. We depend on adequate reimbursement from public and private payers to allow for the recruitment and retention of sufficient numbers of qualified providers with sufficient staffing 24 hours a day, seven days a week. By making it easier to enroll in the Marketplaces, the number of enrollees in government-

² 87 FR. 27208. (May 6, 2022).

³ Kaiser Family Foundation, "The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act," January 2019, available at: <https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-halth-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-care/>

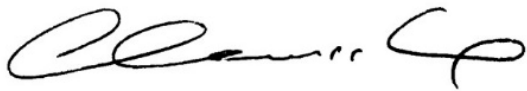
assisted health insurance programs would increase and uncompensated care costs could decline, thereby helping to secure the viability of the emergency care safety net.

New Requirements Related to Agents, Brokers, or Web-brokers

ACEP supports all of CMS' new proposed requirements for agents, brokers, and web-brokers, including requiring these entities to document that eligibility application information has been reviewed and confirmed to be accurate by the consumer prior to application submission. It is imperative that consumers receive accurate information about their health insurance coverage options and do not mistakenly purchase less comprehensive and potentially more expensive health care coverage. Consumers must understand the financial parameters of the health plan they purchase and ensure that the plan best meets their overall needs.

We appreciate the opportunity to comment on this proposed rule. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Kang", with a stylized flourish at the end.

Christopher S. Kang, MD, FACEP
ACEP President

PUBLIC SUBMISSION

As of: 1/28/23, 4:41 PM
Received: January 25, 2023
Status: Posted
Posted: January 27, 2023
Category: Consumer Group
Tracking No. ldc-jzvd-cbul
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0066

Comment on CMS-2022-0192-0003

Submitter Information

Name: Uzoamaka Okafor

Address:

Smyrna, GA, 30080

Email: uzzy.okafor@gmail.com

Phone: 4705967240

General Comment

REF File Code CMS 9899-P

The Proposed Patient Protection And Affordable Care Act HHS Notice of Benefit and Payment Parameters for 2024 is laudable. As an agent in the Marketplace, I believe it will enhance the credibility of the Affordable Care Act, increase the confidence of Applicants in the Marketplace Health Coverage and also maintain the integrity of this System. Every aspect of the proposal seeks to increase consumer participation in the Marketplace for coverage and adequate period to comply with notices regarding completion of their enrollment. Both agents and consumers are protected under the rules being proposed.

Consent of consumers before enrollment is already being implemented by the Marketplace whether they are enrolled directly in the Marketplace or via an Enhanced Direct Enrollment platform because at some point during the enrollment the application is routed through the Marketplace and the agent responds to the question of consent the system poses before continuing the enrollment. Inclusion of diverse populations is noted and very welcome with other languages' inclusion apart from the English Language.

Uzoamaka Marie Okafor.

Agent.

Ref. File Code CMS 9899-P

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of TX OK FL NC SC GA OH MI TN MS KS. I assist my clients with not only picking plans and registering but also when they need help with a Dr or claim. I stay in contact throughout the year to make sure their needs are met.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
 - Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of

income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
- O The Federal Marketplace is connected to the IRS, which should/could help in providing

correct income information.

- The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. ○ The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
- If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
- I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
- I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

- I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

- To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
- I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- Please keep in mind, many consumers do not have access to computers, most have access to phones.
- With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

- This section is speaking about an issue that is happening across the nation to many professionals.
- I know colleagues who have had a “rouge” agent steal their clients.
- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Duong Thuy Le



Signature™
HEALTH

January 27, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

Signature Health is a non-profit, Federally Qualified Health Center providing mental health, addiction recovery, primary care and infectious disease services to patients across Northeast Ohio. Founded in 1993, Signature Health serves people of all ages, regardless of their ability to pay, aiming to eliminate health disparities in our Cleveland area communities.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. OUR ORGANIZATION strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Signature Health welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

Signature Health supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. Signature Health recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, Signature Health recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As OUR ORGANIZATION has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. Signature Health recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, Signature Health believes that these good-faith contracts should extend to all FQHCs in their service area.

Signature Health recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as

¹ Section 1311(c)(1)(C)

² <https://www.ghpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like Signature Health, to engage with states and hold them accountable. Signature Health recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

Signature Health strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program,

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. Signature Health appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. Signature Health appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

Signature Health also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

Signature Health also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person.>

⁶ [https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1\).](https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1).)

churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

Signature Health appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

Signature Health is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community.

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, Signature Health will remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. Signature Health also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

Signature Health supports CMS’ proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers’ interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

Signature Health supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, Signature Health applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and Signature Health also agrees that four tiers in a plans’ drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. Signature Health appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

Signature Health also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OUR ORGANIZATION appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

Signature Health recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection Signature Health supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Jonathan Lee at email jlee@shinc.org or call 440-578-8200 x10110.

Sincerely,

A handwritten signature in black ink, appearing to be 'J Lee', written in a cursive style.

Jonathan Lee
CEO



January 27, 2023

Submitted via www.regulations.gov

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9899-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

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

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Since we opened for business, we have cut the uninsured rate by half and now more than 96% of District residents have health coverage.

HBX supports CMS's policies that provide flexibility for state-based marketplaces (SBMs), allowing states to design programs that best serve the needs of their consumers and allow for state innovation. HBX also applauds and strongly supports CMS for its strong commitment to equity and nondiscrimination. CMS and states need to reexamine all regulatory impediments to enrollment in affordable quality coverage. As such, HBX strongly supports CMS's proposals that would remove barriers to enrollment, such as expanding the availability of special enrollment periods, modifying the income verification requirements to eliminate unnecessary customer documentation requests, limiting the circumstances where customers would be categorically barred from tax credits based on a failure to reconcile, and creating a notification standard prior to plan termination for non-payment of premiums. HBX also supports efforts to increase consumer enrollment by allowing door-to-door Assister/Navigator enrollment and supports strong federal oversight of web-based enrollers as proposed in the NBPP. These proposals are essential to ensuring that consumers can access high quality coverage that meets their needs.



1225 Eye Street NW, 4th Floor, Washington, DC 20005

There is one proposed area that we oppose in its entirety -- the Improper Payment Pre-Testing and Assessment (IPPTA) Program proposal because it is duplicative creating an unnecessary resource burden on SBMs.

Improper Payment Pre-Testing and Assessment (IPPTA) Program (§ 155.1500 et. seq.)

HBX opposes the proposal to create the IPPTA Program, a precursor to the State Exchange Improper Payment Measurement (SEIPM) program that was proposed but ultimately not adopted by CMS in the 2023 Payment Notice. These proposals duplicate existing audits and create significant new financial, system, and resource burdens on SBMs such as HBX. Because existing federal and local audit and reconciliation requirements already satisfy the oversight requirements of the Payment Integrity Information Act of 2019 (PIIA), the proposed new audit is duplicative and unnecessary. To the degree the existing audits and reports do not meet CMS' needs, guidance for such audits and reports should be updated rather than duplicating these with a new audit.

Existing Oversight Measures Meet PIIA Goals

CMS indicates that it must implement the IPPTA program, leading to the SEIPM program, to comply with the PIIA. However, CMS does not provide evidence as to why its existing oversight activities can't be used to conduct the improper payment risk assessment, improper payment estimates, and corrective action plan reporting required by the PIIA. In fact, the 2023 proposed Payment Notice acknowledged that CMS already monitors eligibility and enrollment errors and payment discrepancies through activities that include:¹

- An annual report showing compliance with federal requirements, which includes completion of a programmatic audit by an independent auditor at the exchange's expense;
- Monthly payment dispute reconciliation;
- An annual report on instances in which the State Exchange did not reduce an enrollee's premium by the amount of the APTC in accordance with §155.340(g)(1); and
- Quarterly submission of performance monitoring data.

Given this extensive and frequent oversight framework, adding the IPPTA or SEIPM program to current oversight activities is redundant and unnecessarily burdensome. Adding this new burdensome audit is reminiscent of the early days when SBMs opened. Back then we had federal and local audits, many of which continue: HHS Office of Inspector General audits, HHS Office of Inspector General Cost Allocation audits, CMS SMART audit (annual), CMS Privacy Impact Assessment (triennial), IRS Federal Tax Information audit (periodic), IRS Safeguard Security Report (periodic), Inspector General for Tax Administration (periodic), GAO audits (periodic), GAO Special Enrollment Period audit, GAO IT audit, Comprehensive Annual Financial Report audit (local annual), Single-Audit (for federal grants), Single-Audit for ARP funding, Insurance Regulatory Trust Fund Bureau audits (local annual), DC OIG Risk Assessment of the use of the District's ARPA Funds, and other federal and local one-time, periodic, and annual audits. Requiring new duplicative, burdensome, and resource intensive

¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584, 654 (proposed Jan. 5, 2022).

audits depletes and diverts limited resources from enrollment and support for customers.

In particular, the following oversight and reconciliation activities already target eligibility and enrollment errors or improper payments:

Annual Programmatic Audits – 45 C.F.R. §155.1200(c) requires that an exchange hire an independent auditor to conduct an annual programmatic audit. Unlike the 2023 Payment Notice proposal, this proposed rule lacks a modification to §155.1200 that would exempt exchanges from the annual programmatic audit for those years where they participate in the IPPTA. At a minimum, this exemption must be added back §155.1200(c) so that exchanges are not required to participate in both the IPPTA and the programmatic audit for the same calendar year.

CMS does not provide a reasonable rationale indicating that the IPPTA or SEIPM is a necessary replacement. CMS’s rationale in the 2023 proposed Payment Notice for why it would not simply update its auditing guidelines for independent auditors is falsely premised. First, CMS acknowledges in the that this audit, along with the corrective action plans that CMS monitors closely, “allows HHS to oversee compliance with eligibility and enrollment standards to ensure that State Exchanges are conducting accurate eligibility determinations and enrollment transactions.”² The independent auditors conduct these audits pursuant to CMS guidelines while allowing for necessary adjustments to ensure they are collecting the right data. Contrary to CMS’s assertion that using different “third-party reviewers” to make improper payment estimates would undermine the utility of the results,³ meaningful review must allow auditors to adjust for each marketplace’s unique eligibility and enrollment system architecture and market conditions. Such adjustments are crucial to ensuring the audit results are accurate. For example, in 2022, only 17% of HBX’s individual market enrollees received APTC. Recognizing this, our independent auditor created separate samples that test enrollment eligibility generally as compared to APTC eligibility specifically. Second, CMS has said that engaging “third-party reviewers” to estimate improper payments would place an additional burden on CMS and the SBMs because “the third party would need to obtain personally identifiable information from both state and federal data systems.”⁴ However, for the current programmatic audits, the independent auditors already receive extensive PII, information returned from federal data services that were used to verify eligibility, and data on the amount of APTC associated with all enrollments. Additionally, the independent auditors already make findings as to eligibility and enrollment errors. They could easily formulate improper APTC payment estimates.

Monthly Payment Dispute Reconciliation – On a monthly basis, CMS sends data files to exchanges to reconcile discrepancies between the APTC amounts issuers are claiming and the amounts reported to CMS by SBMs. Although HBX’s experience indicates there are infrequent and easily explained discrepancies, these monthly engagements between CMS and HBX allows HBX to promptly make necessary corrections by updating the

² 87 Fed. Reg. at 654.

³ 87 Fed. Reg. at 718.

⁴ 87 Fed. Reg. at 718.

reporting in the next month's SBMI file and to address any systematic issues that may be creating the discrepancies. This is one of many ways CMS now has to assess improper payment risk and to estimate amounts of improper payments.

APTC Reconciliation - The ACA requires reconciliation of APTC on an individual's tax filing⁵. APTC determinations are based on whether the applicant is "expected to have a household income that will qualify" them for premium tax credits.⁶ As such, the applicant must provide an estimation of income before the year is complete or before the year has even started in the case of applications and renewals in November and December for January 1 coverage. An individual is then required to reconcile the APTC on tax filings after the enrollment year ends. Any amount of over payment or underpayment is determined through review or adjudication by the IRS. Errors in calculation or documentation are overcome by the reconciliation of actual income earned and premium tax credit due. Instead of establishing an error rate which isn't appropriate or comparable to other healthcare programs given the reconciliation requirement, CMS and IRS should continue to use the oversight and audit requirements in place to identify and remedy improper payments.

HBX Supports Commitment to Minimizing Burden on SBMs

While HBX opposes the IPPTA program for the reasons stated above, and we ask CMS to reject the proposal in its entirety, if CMS proceeds with imposing this duplicative requirement, HBX encourages CMS to minimize the administrative burden on SBMs. CMS should also retain the proposed rule's language requiring strong coordination and consultation with SBMs as such consultation is crucial to collecting accurate information. CMS should adopt the proposal to:

- Allow SBMs to provide the application data associated with the sampled applicants, including electronic data responses, and CMS would use its own resources to map the data to the data elements they desire.⁷ As noted by CMS, this would require a close level of interaction between CMS and the exchanges to ensure CMS is interpreting the data properly.
- Allow SBMs to provide information on 10 tax households, as proposed.⁸ Data samples must be the minimum necessary to validate an SBM's eligibility processes. A sample of ten is sufficient and would help mitigate additional operational and resource burdens on an SBM. Importantly, CMS must allow for SBM documentation, such as the "entity relationship diagram" and "data dictionary", to be in various formats which would differ from other SBMs and the FFM. CMS should not expect SBMs to create new documentation to satisfy the IPPTA as this would be resource intensive and would divert limited resources from the exchange's central mission of helping people get covered and stay covered.

⁵ 26 U.S.C. §36B(f); 26 C.F.R. §1.36B-4.

⁶ 45 C.F.R. §155.305(f)(1)(i).

⁷ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 78206, 78271 (proposed Dec. 21, 2022).

⁸ 87 Fed. Reg. at 78271.

Finally, CMS should postpone any action or decision until after the current pilot program is complete, evaluated, and lessons identified. The FFM and SBM-FPs are measuring and reporting their improper payments as of 2022, and some SBMs are engaged in a voluntary evaluation process. HHS provided three options to State Exchanges—program analysis, program design, and piloting. Currently, of the 18 State Exchanges, 10 have participated in various levels of engagement. If CMS chooses to move forward with the IPPTA or duplicative audit requirements, it should only be after the current pilot states have fully completed their pilot and best practices can be used in the extension of these requirements to other states.

For the above-stated reasons, HBX opposes the proposed IPPTA program, a precursor to the SEIPM program. We ask CMS to reject this proposal in its entirety as duplicative, unworkable, unnecessary, and overly burdensome and instead devise mechanisms wherein it uses data already known to CMS, combined with existing audits, to meet its oversight obligations.

Conclusion

Thank you for considering our comments on issues that will directly impact District residents and the continued operations of our marketplace. We appreciate CMS's continued support for state flexibility consumer protections and working to ensure a more equitable future. We look forward to working with you on these issues.

Sincerely,

A handwritten signature in dark ink, appearing to be 'Mila Kofman', with a long, sweeping horizontal line extending to the right.

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority

January 27, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Regulations.gov

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2024 (Notice), as published in the Federal Register on December 21, 2022, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and five United States territories.

First, we appreciate the Department's effort to publish the proposed Notice somewhat earlier than in some prior years. As NAIC has noted in past comments, publishing and finalizing the Notice earlier gives health insurance issuers and state regulators more time to develop and review plans and rates for the relevant year. We further appreciate the somewhat longer comment period—allowing more than 30 days gives NAIC, individual state regulators, and other organizations a greater opportunity to offer meaningful comments.

State Requests to Reduce Risk Adjustment Transfers

The proposed Notice would repeal the ability of states to request a reduction in risk adjustment state transfers, including for the state that has previously requested and been approved for a reduction. State regulators object to this change. State regulators recognize the importance of risk adjustment in maintaining predictable premiums and attracting issuers to markets. But unique dynamics in an individual state's insurance market can result in undesired outcomes when applying the federal risk adjustment methodology, which must be developed and applied nationwide. State regulators have the detailed understanding of their state markets necessary to recognize the rare instances when the federal risk adjustment methodology is inappropriate for a state's market.

Under current policy, states must apply for and receive approval from the Department of Health and Human Services (HHS) to reduce risk adjustment transfers. This approval process leaves the final determination up to HHS and allows for states to provide justification for reducing risk transfers when conditions warrant. Foreclosing the opportunity for states to apply for reductions in transfers pre-judges all future market conditions. State regulators believe it is preferable to retain the current approach and keep open the possibility for states to make applications. Because HHS has the authority to disapprove an application if a state fails to provide adequate justification, it is not necessary to disallow requests.

If the change in policy is finalized as proposed, state regulators support an ongoing exemption for the single state that has previously requested and been approved for reduced risk adjustment transfers. We also support Alabama's request to reduce its transfers for the upcoming year.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards

The Notice proposes to remove some prohibitions on Navigators, non-Navigator Assistance Personnel, and Certified Application Counselors using door-to-door and other unsolicited means of direct contact to provide application or enrollment assistance to consumers. As state regulators, we appreciate HHS's well-intentioned proposal as a way to get more consumers enrolled in health coverage and to address health disparities by making it easier for consumers to enroll. However, several state legislatures have enacted laws requiring state licensure of assisters and many of these laws draw a distinction between the duties of an assister and the duties of a separately licensed insurance producer. HHS recognized the importance of state licensure in the current rules, requiring Navigators, non-Navigator Assistance Personnel, and Certified Application Counselors to comply with licensing, certification, or other standards prescribed by the state or exchange. We encourage HHS to specify that the removal of some of the prohibitions regarding door-to-door and other unsolicited means of direct contact do not preempt state law prohibitions against Assisters selling, soliciting, or negotiating health insurance unless also licensed as a producer.

Documentation Requirements for Agents and Brokers

The Notice proposes to adopt new requirements on agents, brokers, and web-brokers to document consumers' consent to representation as well as consumers' confirmation of the accuracy of submitted application information. State insurance regulators appreciate HHS' efforts to enforce protections against misconduct on the part of agents and brokers and we believe these requirements will both encourage stricter compliance with standards and aid in investigations of possible agent and broker misconduct. We encourage HHS to maintain the flexibility it has proposed in

operationalizing these requirements. Allowing agents and brokers to use different electronic means, forms, or recordings to document consumer consent will allow agents and brokers to comply with the federal regulation while also meeting any similar state requirements. We note that the 10-year retention requirement for such records may exceed state records retention policies, which may cause some confusion for agents and brokers. HHS may wish to align records retention periods with state policies when appropriate.

Reenrollment Hierarchy

The Notice proposes to give Exchanges authority to alter the reenrollment hierarchy. It would allow Exchanges to move enrollees in bronze plans who are eligible for cost-sharing reductions to silver plans (with the same issuer and product) in the next plan year if their net premium in the silver plan would be the same or lower. Exchanges would need to consider the similarity of different plans' networks when making reenrollments in several scenarios. State insurance regulators recognize the potential benefit to consumers of moving them to a silver plan variation that offers lower cost sharing with the subsidy. We support giving Exchanges the option of making these changes to reenrollment hierarchies so that state-based exchanges can choose whether the revised hierarchy is in the best interests of consumers and insurance markets in their states.

In operationalizing this authority for the federally-facilitated exchanges, we urge HHS to consult with state insurance regulators on any impacts of the change, particularly regarding network similarity. Some regulators are concerned that overriding an enrollee's prior choice of plan level may create disruptions, particularly when networks are similar but not identical. States may use different practices in setting policies for the assignment of network IDs, so it would be helpful for HHS to engage directly with states to better understand how networks differ based on ID. We appreciate HHS' ongoing engagement with NAIC and state regulators on provider network issues and anticipate using that engagement to enhance understanding on both sides.

SEP for Loss of Medicaid

As Medicaid continuous enrollment comes to an end, state agencies across the country will begin Medicaid eligibility redeterminations, which is expected to result in millions of individuals losing Medicaid coverage and seeking coverage through the exchanges. State insurance regulators support the proposed extension, from 60 days to 90, for reporting loss of coverage and enrolling in an exchange plan. This extended timeframe will serve as an additional safety net for individuals newly navigating tax credit eligibility and commercial plan options. Also appreciated are the proposed efforts to ensure consumers experience little to no gaps in coverage as

they transition from Medicaid to exchange plans. We are supportive of the flexibility provided to state-based exchanges in implementing these provisions.

FFE and SBE-FP User Fee Rates

State insurance regulators support a reduction in user fee rates. Consumers should see some benefit as lower fees are passed along in the form of lower premiums. We encourage HHS to continue to find efficiencies in the operation of the federally-facilitated exchanges and the federal platform so that it can further reduce rates in the future.

Non-Standardized Plan Option Limits

The Notice proposes to limit the number of non-standardized plan options issuers may offer through federally-facilitated exchanges. Issuers would be limited to two non-standardized plans per network type at each metal level. Alternatively, HHS would apply a meaningful difference standard and prohibit plans that are not meaningfully different from others offered by the same issuer, based largely on deductible amounts. State insurance regulators support a flexible approach that allows for variation based on market conditions in each state.

Some state regulators have concerns about the high number of plan options offered through their federally-facilitated exchanges and would support regulatory changes to limit the number of plan choices. When consumers are faced with dozens of plan choices it is more difficult for them to identify the plan that best meets their needs. Common plan search and display designs can hide plans from some issuers when other issuers market a high number of plans with only slightly different features. Thus, limiting plan offerings or assuring they are meaningfully different from each other can improve consumer outcomes and promote competition among issuers.

Other states, however, wish to promote competition by allowing issuers to innovate and offer the number of plans that best suits their markets, their customers, and their competitive strategies. Some regulators want to maintain issuers' ability to market plans that offer features some consumers desire, even when relatively few consumers choose a certain plan.

The number of plan offerings nationwide has increased in the last few years, but there remains significant variation by state and by service area. The numbers HHS cites in discussing its proposals to limit offerings are averages across all federally-facilitated exchanges. Many areas have fewer than the average number of plans. State regulators are best situated to understand the dynamics of their state markets and assess when limits on the number of plan options should be applied. Thus, state regulators recommend a more flexible approach to plan options than either alternative outlined in the proposal. At a minimum, HHS should allow states to opt out

of the plan limit and allow more plan offerings when the chief insurance regulator determines this would be in the best interest of the state's consumers. More flexibly, HHS could allow states to specify a different limit applicable in the state.

Flexibility could also be added to the meaningful difference alternative. HHS could allow a state to choose additional criteria on which plans could vary and be considered meaningfully different. For example, HHS could allow states to select one or more of the criteria in the 2015 meaningful difference standard, including cost sharing, provider networks, covered benefits, and Health Savings Account eligibility. A state may wish to allow differences in these plan features to distinguish plans as meaningfully different and permit more non-standardized plans to be offered side-by-side. More generally, HHS could consult with state regulators during the QHP certification process and collaborate with them in determining whether the plans offered by a particular issuer are meaningfully different.

State regulators support the state flexibility HHS proposes with regard to exchange type. Allowing state-based exchanges to make their own choices regarding non-standardized plan options supports the state-based exchange model. It recognizes the varied approaches states may choose to manage their QHP markets as well as the challenges presented by shifts in federal rules on plan offerings.

Plan and Plan Variation Marketing Name Requirements for QHPs

The Notice proposes a new requirement that QHP plan marketing names include correct information that is not misleading. State insurance regulators support this new requirement. We have observed plan marketing names that omit key information and can easily mislead consumers into believing that some services will be covered at no cost when important conditions and limitations apply. We anticipate continued collaboration with federal officials in enforcing this requirement once it is finalized. In considering standardization of plan marketing names, we suggest HHS include network type as one potential standardized element. The availability and relative cost of out-of-network benefits is an important consideration for some consumers and an indication in the plan name would be a prominent way to signal plan differences in this area.

Plans That Do Not Use a Provider Network: Network Adequacy

The Notice proposes to revise the network adequacy standards to state that all Stand-Alone Dental Plans (SADPs) across all exchanges must use a network of providers. The Notice recognizes that, if this proposal is finalized, it can be more challenging for SADPs to establish a network based on the availability of nearby dental providers in states like Alaska and Montana. The Notice seeks comment on whether HHS should finalize a limited exception to the network requirement for SADPs that sell plans in

areas where it is prohibitively difficult for the issuer to establish a network of dental providers.

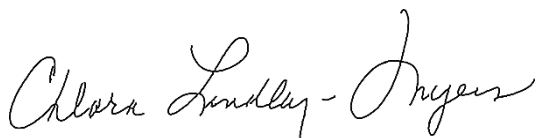
As explained in more detail in the separate comment letter submitted by Montana's Commissioner of Securities and Insurance, consumer choice of SADPs on the exchange would be negatively affected should the network requirement for SADPs be adopted because it would result in removal of three out of the five issuers currently offering SADPs on the exchange for Montanans. If this requirement is finalized, the NAIC supports HHS establishing a limited exception for SADPs that sell plans in areas where it can be prohibitively difficult for SADPs to establish a network of dental providers.

Compliance With Appointment Wait Time Standards

The Notice proposes to apply the network adequacy standard related to appointment wait times beginning with plan year 2024. State insurance regulators appreciate the decision in the 2023 Notice to delay this aspect of network adequacy reviews. However, we remain concerned with the availability and reliability of data to demonstrate compliance with this standard. HHS expects to rely on issuers' attestations of compliance with the standard. It remains unclear what data or measures on which issuers are expected to base their attestations. Neither state nor federal regulators have appropriate tools to assess whether attestations are accurate. While the waiting time until an appointment is a key aspect of access to care and an important indicator of network adequacy, state regulators urge more detailed development of related measures before robust enforcement of this network adequacy standard.

Thank you for the opportunity to comment on HHS' proposed updates to regulations in these areas. We appreciate your consideration of state regulators' perspective on the proposals and their potential impact on consumer protections and market competition. We are available to discuss these or other issues as HHS continues its work and the Notice is finalized.

Sincerely,

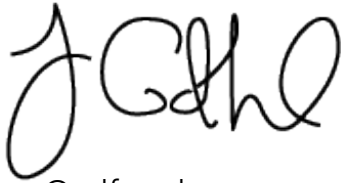


Chlora Lindley-Myers
NAIC President
Director



Andrew N. Mais (He/Him/His)
NAIC President-Elect
Commissioner

Missouri Department of Commerce
and Insurance

A handwritten signature in black ink, appearing to read 'JGdhe'.

Jon Godfread
NAIC Vice President
Commissioner
North Dakota Insurance Department

Connecticut Insurance Department

A handwritten signature in black ink, appearing to read 'S White'.

Scott White
NAIC Secretary-Treasurer
Commissioner
Virginia Insurance Department



January 27, 2023

Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Administrator Brooks-LaSure, Secretary Becerra, Deputy Director Dr. Montz, and the entire staff involved with research and development of this proposal,

We are writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. We appreciate the opportunity to provide comments on this important proposed rule.

For context, and full disclosure, our organizations are:

PA Health Advocates, a healthcare brokerage focused on helping individuals navigate the health insurance market. Our expertise in the individual health market allows us to work directly with customers across 13 total states spanning both FFM and SBM Markets.

SnapHealth, our Benefit LLC is digitizing many of PA Health Advocates processes with an expressed mission of improving patient health. With a digital system, we leverage Interoperability, Patient Access API, FHIR/ONC Protocols, and No Surprises Act Transparency regulations to bring robust tools direct to consumers to not only acquire quality health insurance, but be provided tools to actually interact with the health markets efficiently.

Helping Health, our 501(c)(3) nonprofit operates as a community-based organization serving the Pennsylvania Market to assist the market in applying for Medicaid and Financial Assistance applications through hospital Charity Care programs.

We have three core missions within the financial side of healthcare: 1) working one-on-one with consumers to help them efficiently navigate the system, 2) working with trade groups and government workgroups at HAFA, NABIP, CMS/CCIIO, and Pennie to indirectly help the broader market and advise on consumer needs, and 3) working with Congress and government agencies to report inadequacies, inequities, and consumer catastrophic claims that need policy changes to stop dangerous recurring events.



We have carefully reviewed the proposed rule and have comments to offer regarding the following topics.

- No Binder Payment – Zero Premium Remapping
- Section 153(2)(A) Market Adjustment
- Section 155.106 State Waiver Timelines
- Section 155.210(d)(8) Navigator Marketing
- Section 155.305 Failure to Reconcile Extension
- Agent/Broker Consent
- Section 155.315/155.320 Income Attestations
- Section 155.335 Annual Mapping
- Section 155.420 Mid Month SEP
- Section 155.420(d) Provider Network Change SEP

No Binder Payment – Zero Premium Remapping

The proposed rule asks for comment on move consumers to a zero-premium plan in the event the consumer enrolls in a qualified health plan during open enrollment, but fails to pay their premium by the 12/31 deadline.

We would like to express our concerns about the proposal to automatically move consumers who do not pay their binder payment by the deadline to a zero-premium plan. While we recognize that the zero premium plan may be more affordable for some consumers and provide a safety net for those at risk of losing coverage, there are also several potential drawbacks to this proposal.

One concern is that the automatic switch to a zero premium plan could be confusing and disruptive for consumers, who may not have been expecting to be enrolled in a different plan. The new plan may not offer the same coverage or provider network as the original plan, which could cause difficulties for consumers who are already receiving care or have established relationships with certain providers.

Additionally, consumers may not have a choice in whether to switch to the zero-premium plan, even if they prefer their original plan or are able to pay their binder payment at a later date. This could limit their ability to make informed decisions about their healthcare coverage.

Finally, in previous years, we have noted that the accuracy and timeliness of outstanding premiums have not always been accurate. Consumers may make a binder payment, but if the data isn't shared from the carrier to the marketplace either accurately, or by the deadline, the consumer may be mapped to another plan causing further confusion.

Overall, while we recognize the potential benefits of the zero-premium plan, we believe that it is important to carefully consider the potential drawbacks and ensure that consumers have the ability to make informed decisions about their healthcare coverage.



Section 153(2)(A) Market Adjustment

The proposed rule asks for comments on determining the market basket update as outlined in section 153(2)(A) of the Affordable Care Act. As you are aware, the COVID-19 pandemic has had a significant impact on healthcare costs, with spending increasing by over 10% in 2020 according to a recent study published in Health Affairs (<https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.01397>).

Considering this, we believe it is important to consider options that take into account the unusual circumstances of 2020, consider smoothing over both this coming plan year and future years, and ensure that payment rates accurately reflect the current market conditions for healthcare services.

Based on your recommended options, and the Health Affairs study, we believe it will be prudent to use data from 2017–2020 in order to spread out the assumption of the increase in costs over a longer time period. This would also hold true for the next NBPP that will account for the 10% spike in 2020, but also use the lower-than-average spending reflected in 2021 numbers. It may be prudent to adjust 2017 numbers due to inflation to reflect spending more accurately.

We appreciate the difficult task of determining payment rates in the face of unprecedented challenges, and we hope that these suggestions may be helpful in your considerations.

Section 155.106 State Waiver Timelines

The proposed rule addresses a concern that we share about the current timeline for states to transition to a State Based marketplace. As outlined in section 155.106, states are required to have 3–14 months (depending on type of waiver) from the time CMS greenlights their transition to when their system can be live for open enrollment. We believe that this timeline is insufficient and that CMS should have more time to properly prepare for this transition. We have now participated in the PA, NJ, MD, and NM (and VA currently) markets as they transitioned away from FFM, and states need more ramp up time to iron out kinks.

There are several reasons why we believe that CMS and states should have more time to transition to their SBM marketplace. First and foremost, this will help individual consumers to have more time to prepare for this transition. Many individuals rely on the ACA marketplace for their healthcare coverage, and a rushed transition could lead to confusion and uncertainty for these individuals. By giving states more time to transition to the SBM marketplace, individuals will have the opportunity to better understand what the shift means. An example of prior transitions was in Pennsylvania (our resident state). We routinely met consumers who believed that **the plans** were different because they couldn't get healthcare.gov coverage anymore.

Additionally, more time for the transition will benefit insurers and enrollers as well. Insurers and enrollers need time to prepare for the transition to the state's marketplace, including updating their systems and processes to comply with the new requirements. A core tenant of the SBM waiver is for states to show how their unique approach to the market would save federal funds. This "unique" autonomy adds additional considerations for insurers and enrollers as state level rule making varies from FFM rules. A rushed transition could lead to delays and difficulties for these stakeholders, which could ultimately impact the quality of care and coverage that individuals receive. By giving states more time to transition



to the SBM marketplace, insurers and enrollers will have the opportunity to properly prepare and ensure that they are able to provide high-quality care and coverage to individuals.

In conclusion, we strongly believe that CMS and states should take more time to transition to SBM marketplaces. This will help individuals, insurers, and enrollers to have more time to prepare for this transition and ensure that the marketplace is able to function effectively and efficiently. We encourage CMS to consider extending the timeline for the transition to the State marketplaces to allow for a smoother and more successful transition.

Section 155.210(d)(8) Navigator Marketing

Next, we have concerns about the potential impact of removing subsection (d)(8) of 45 CFR § 155.210 from the ACA. This provision currently prohibits navigators from conducting door-to-door enrollment activities. We believe that removing this provision could have several potential negative consequences.

Allowing navigators to conduct door-to-door enrollment activities could raise concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from enrollment assistance staff. It could also lead to confusion or misunderstandings about the nature of the assistance being offered, as some consumers may not be aware that navigators are trained and certified by the Department of Health and Human Services (HHS) to provide assistance. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.

Similar to the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.

Lastly, we feel very strongly that both Navigators and Brokers have a separate and distinct role within the health insurance market for individuals. Consumers above 150% of the Federal Poverty Limits, especially those with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not brokers, you are keeping a better qualified resource, the broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

We urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.



Section 155.305 Failure to Reconcile Extension

The proposed rule makes mention of potential change to Section 155.305 of the ACA, which currently requires exchanges to remove premium tax credits (PTCs) if the IRS determines that an individual did not reconcile their PTCs for the previous year.

One potential pro of changing the rule to a two-year period is that it could give individuals more time to reconcile their PTCs and avoid having to pay back any excess credits. This could be particularly beneficial for individuals who have complex financial situations or who have difficulty navigating the process of reconciling their PTCs. In addition, such a change could help to prevent situations where individuals have filed an extension with the IRS in April and have not yet filed their return by the time the IRS reviews PTCs, resulting in the exchange removing PTCs even though the individual's tax situation may ultimately be found to be in compliance.

However, we also recognize that there are potential cons to changing the rule to a two-year period. One concern is that a two-year reconciliation period could lead to more instances of fraud or abuse, as individuals may be able to receive excess credits for a longer period of time before they are detected and required to pay them back.

One further consideration is that for individuals who exceed 400% of the federal poverty limit, the amount of PTCs they could be subject to pay back could be much higher than for lower income households, and a two-year reconciliation period could result in a higher repayment effect for these individuals.

We believe that the decision to change the rule from a one-year to a two-year period should be carefully evaluated, taking into account the balance of the potential pros and cons as well as the specific circumstances and needs of the individuals and small businesses participating in the exchanges.

Agent/Broker Documented Consent

The proposed rule seeks feedback on a proposal that agent, brokers, or web-brokers must document a consumers consent to help them prior to assisting the consumer

In reviewing this proposal, we first recognize that ALL enrollers (Agents/Brokers/Web-Brokers/FFM Call Center Representatives/Navigators/Assistors/CACs) DO NOT have independent discretionary authority (without some form of consent by consumer) to:

1. View an individuals PII/PHI
2. Pick which plan the consumer enrolls in
3. Effectuate coverage without the expressed consent of a consumer.

This is both indoctrinated in law, but also good ethical practice. No one should be accessing your or my information without consent. This should be a simple practice.

Currently, in order for an enroller to access any information about a consumer through the FFM, they must either use a DE or EDE platform, or assist their client directly from the client side healthcare.gov portal. It is illegal to create, maintain, or use healthcare.gov consumer credentials. Because of this, we



see that the effort in this proposal is to document consumer consent DE and EDE access and interaction with consumer data.

Within the DE and EDE frameworks, any time an enroller looks to access and subsequently pull a record into their account, the enroller is required to attest "I've received permission from this consumer to work on their behalf." Additionally, within the Agent Broker General Agreement that must be signed each year, it states: "ABE may only conduct person searches for Consumers who have given the ABE consent to access and use their personally identifiable information for purposes of assisting the Consumer in applying for and enrolling in a QHP or other Insurance Affordability Program through an FFE or SBE-FP." This is CURRENTLY in place.

Misrepresenting this attestation constitutes fraud. Under 45 CFR § 155.220(f)–(m) outline the recourse that HHS has at their disposal to deter bad actors from misrepresenting this consent.

Fundamentally, we see two issues when it pertains to consent. 1. Misrepresentation and Enforcement. According to the AB Registration Completion List, for plan year 2023 there are over 74,000 brokers supporting individuals. Additionally, since 2016 there are around less than 700 that are terminated from the FFM. When looking at the data, it can be inferred that either 99% of brokers are in compliance, and/or enforcement is down. When looking at the AB suspension list, it does look as if more bad actors are being removed than years past. That said, what we hear from other Agents/Brokers who have reported bad eggs, they note many cases where no action is taken. Additionally, within CCIO we have been told that mechanisms used to track complaints alert the teams of suspicious activity that results in "reminding the AB that they can't just access data without permission." Before any consequences are passed on.

Our concern is that adding a requirement that a broker get a form signed consent is adding additional steps to a consumers enrollment process that is already addressed by the broker DE/EDE attestation and current policy. Bad actors will continue to skirt regulations and need to be removed through enforcement. Good actors, and consumers shouldn't be required to hold account.

Consumer Review Attestations

The proposed rule suggests that a consumer attest that they have read and reviewed all information before the enroller has submitted their plan. We see concerns when we parallel the role of an enroller to other professional industries. When you need healthcare, or legal help, or tax and accounting work, you are often leaning on the guidance of others to help you from the moment you make your problem known, to the solution. When it comes to enrollers, regardless of ABs, or Navigators, the questions are usually asked of the consumer, and inputted by the enroller.

That said, when a person is not face to face, they are not reviewing each and every input as they are typed in. Because of this, we see a problem with consumers being required to attest to reviewing an application. Many consumers have never logged into their account, have relied on the enroller and the DE/EDE system, and have had their plan selection finalized by the enroller, and paid the premiums they have to the carrier.



We see a barrier to enrollment if enroller has to read an attestation to a consumer that they are having a call with and either the call needs to stop and the individual must open the app on their end and complete it, or the client gives a verbal authorization and reviews the application after the fact. I think the various ways that consumers seek help and buy insurance should be considered before implementing this type of attestation.

Section 155.315/155.320 Income Attestations

The proposed rule solicits comments on the use of consumer attestation in the ACA Health Insurance Marketplace to address income inconsistencies. Section 155.315 and 155.320 of the Affordable Care Act (ACA) relate to income inconsistencies when an individual is applying for coverage through the exchange. These provisions require that the exchange verify an individual's income in order to determine their eligibility for premium tax credits and other cost-sharing reductions.

One option for addressing income inconsistencies is for the exchange to accept an attestation from the consumer, in which they affirm that their projected income for the coming year will be different from their prior year income. While this approach has the potential to be more streamlined and efficient, and may be more convenient for the consumer, there is a risk that the consumer's attestation may not accurately reflect their actual income for the coming year. Additionally, if the exchange relies solely on an attestation and does not verify the consumer's projected income, it may be more vulnerable to fraud or abuse.

In Pennsylvania, the current process for addressing income inconsistencies involves requiring the consumer to submit their taxes, two additional documents, and undergo an outbound call from the state before an attestation can be accepted. While this process may be more thorough in terms of verifying income, it may also be more burdensome for consumers compared to simply accepting an attestation without these additional requirements. There are a few ways in which accepting an attestation may reduce the burden on consumers compared to the current process in Pennsylvania: it may reduce the amount of paperwork that consumers need to complete, reduce the risk of transmitted documents being at risk of cyber security events, allow for a quicker resolution of income inconsistencies, and be more convenient for consumers.

Overall, it may be necessary to balance the convenience and efficiency of accepting an attestation with the need to ensure accuracy and prevent fraud. In states, like Maryland, we have seen an attestation with a space to explain why prior electronic data of income, and prior tax documents may not reflect upcoming income. This would strike a balance between the risk and reward as consumers will not only attest to their projected MAGI, but offer an explanation as to WHY it is changing. Events like having a child, retirement, self employed income swings, and many other life events routinely cause MAGI changes that can be explained within the attestation.

Section 155.335 Annual Mapping

Section 155.335 of the Affordable Care Act (ACA) relates to the annual process of redetermination, which involves reviewing an individual's eligibility for premium tax credits and cost-sharing reductions



(CSR) and determining the appropriate level of assistance. This provision currently requires the exchange to map individuals to different plans based on their income and household size, as well as other factors such as their tobacco use and any special enrollment circumstances.

If CMS were to change this provision to include network IDs, net premium, maximum out-of-pocket (MOOP), and CSR in the mapping process, it could have some potential pros and cons:

Pros:

- Adding these factors to the mapping process could provide a more comprehensive and accurate assessment of an individual's needs and preferences. Network IDs, for example, could be helpful in determining whether a particular plan is a good fit for an individual based on their access to preferred providers.
- Including net premium and MOOP in the mapping process could help ensure that individuals are enrolled in a plan that is affordable and meets their financial needs.
- Incorporating CSR in the mapping process could help ensure that individuals receive the appropriate level of assistance based on their income and other factors.

Cons:

- Adding more factors to the mapping process could make it more complex and time-consuming for the exchange to develop multiple use cases to find the appropriate plan for an individual. This could lead to delays in the redetermination process.
- It could also be more challenging for individuals to understand and navigate the mapping process if there are more factors to consider and it isn't clear from the prior plan to the new plan, which variables are the most prudent.
- There may be additional administrative and logistical challenges involved in implementing these changes, which could impact the overall efficiency and effectiveness of the redetermination process.

Additional consideration of Gold plans vs CSR73:

As for the idea of considering a map to a gold plan when someone has CSR73 if the premium is cheaper, this could potentially be a good idea in some cases. Gold plans generally have higher premiums than other metal levels, but they also typically offer lower out-of-pocket costs and more comprehensive coverage. If the premium for a gold plan is cheaper than the premium for a plan with CSR73, it may be worth considering for an individual who is eligible for CSR73. However, it's important to keep in mind that there are other factors that may also be relevant, such as the individual's access to preferred providers, their financial needs and preferences, and their overall health status. It may be helpful for the individual to carefully compare the costs and benefits of different plan options to determine which one is the best fit for their needs.

Section 155.420 Mid Month SEP

The proposed rule seeks feedback on changes to Section 155.420 of the Affordable Care Act (ACA).

This section relates to special enrollment periods (SEPs), which allow individuals and families to enroll in



a health insurance plan outside of the annual open enrollment period. According to this provision, the start date for an SEP is typically the month following the event or enrollment, whichever is later. This means that if an individual experiences a qualifying event (such as a change in employment status or a move to a new area) that allows them to enroll in a new plan through an SEP, their coverage will typically begin the month after the event or their enrollment date, whichever is later.

Allowing the start date for an SEP to be whichever is earlier (rather than whichever is later) could potentially have some pros and cons:

Pros:

- Allowing consumers to enroll on the first of the month that has a loss of coverage mid month could allow them to get coverage sooner in some cases. For example, if an individual experiences a qualifying event in the middle of the month and enrolls in a new plan through an SEP, their coverage would typically start the following month under the current rules. Removing this requirement could allow their coverage to start earlier, potentially reducing any gap in coverage.
- This change could also help ensure that individuals have access to timely and continuous coverage, which is important for their overall health and well-being.

Cons:

- Making this change, however, could result in individuals enrolling in a new plan earlier than they intended or were aware of. For example, if an individual experiences a qualifying event and enrolls in a new plan through an SEP, but does not realize that their coverage will start immediately, they may end up paying premiums for coverage they do not need.
- This change could also potentially result in confusion or misunderstandings about when coverage will begin, which could lead to issues with billing and payment.
- Allowing the start date for an SEP to be whichever is earlier could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

Overall, it's important to carefully consider the potential pros and cons of allowing the start date for an SEP to be whichever is earlier before making any changes to this provision. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

Section 155.420(d) SEP for Network Changes

The Centers for Medicare and Medicaid Services (CMS) is proposing a change to section 155.420(d) of the Affordable Care Act (ACA) that would create a special enrollment period (SEP) for individuals who are enrolled in a qualified health plan (QHP) and whose provider is no longer in network during the plan year.

This change could potentially have some pros and cons:

Pros:



- Creating an SEP in this situation could allow individuals to enroll in a new QHP that includes their provider in its network, which could be important for maintaining access to care. This could be particularly beneficial for individuals who have ongoing medical conditions or needs that require ongoing treatment from a specific provider.
- An SEP could provide a more flexible and responsive solution to changes in provider networks, as it allows individuals to enroll in a new plan if their provider is no longer in network.

Cons:

- Creating an SEP could potentially lead to disruptions in coverage and additional administrative burden for individuals, as they would need to enroll in a new plan and potentially switch to a new provider. This could also be disruptive for providers, as they may need to transfer medical records and establish a new care relationship with the individual.
- An SEP could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

One alternative approach to addressing provider network changes could be to require the provider to accept in-network rates through the end of the plan year. This approach could have some pros and cons as well:

Pros:

- Requiring the provider to accept in-network rates through the end of the plan year could help ensure that individuals have continuous access to care without the need to switch providers or enroll in a new plan.
- This approach could also reduce administrative burden for individuals and providers, as it would not involve enrolling in a new plan or transferring medical records.

Cons:

- Requiring the provider to accept in-network rates may not be feasible in all cases, depending on the terms of the provider's contract with the insurer.
- This approach could potentially result in financial implications for the provider, as they may not receive their usual reimbursement rate for the services they provide.
- It could also have financial implications for the insurer, as they may need to pay higher rates to the provider in order to ensure that individuals have access to care.

Another Alternative Approach is requiring provider and insurer contracts to run on a calendar year basis and finalized before the plan year open enrollment period. This, also, could potentially have some pros and cons:

Pros:

- Having provider and insurer contracts run on a calendar year basis could potentially provide more stability and predictability for individuals, as their coverage would be aligned with the



calendar year. This could make it easier for individuals to understand and plan for their healthcare needs and expenses.

- A calendar year basis could also provide more clarity and consistency for providers, as their contracts would be aligned with the same timeframe. This could potentially reduce administrative burden and make it easier for some providers to plan for their practice.
- Aligning provider and insurer contracts with the calendar year could also potentially make it easier to track and report on healthcare utilization and costs, as there would be a clear and consistent timeframe for these metrics.

Cons:

- Requiring provider and insurer contracts to run on a calendar year basis could potentially result in disruptions or gaps in coverage for individuals if they experience a qualifying event that would normally trigger an SEP. For example, if an individual experiences a change in employment status or a move to a new area during the middle of the year, they may not be able to enroll in a new plan with their care team until the following year.
- This approach could also potentially create financial challenges for providers, as their contracts would be limited to a calendar year timeframe. This could make it difficult for some providers to plan for their practice and manage their financial resources.
- It could also have financial implications for insurers, as they may need to adjust their rates and premiums to align with a calendar year basis.

Overall, it's important to carefully consider the potential pros and cons of requiring provider and insurer contracts to run on a calendar year basis before making any changes. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

We appreciate the opportunity to weigh in on these important topics. If you have any questions, please feel free to contact me at jbrooker@pahealthadvocates.com or 717-400-1244.

Sincerely,

Joshua Brooker, REBC®, ABHP, ASFC

CVO & Principal | Advocate for a Better US Health System By Working With Clients, Government, Industry Groups, and Press

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of Texas. I live in a rural area and have been working to bring information about health insurance options to a community that has been historically underserved in this market due to the remote nature of their lives.

Lack of resources, disinformation and general distrust of institutions has created an environment where people do not look into these options; having someone from their community who is able to provide accurate information in a way they can understand has helped many people who would not have otherwise gotten insurance, through the Marketplace or anywhere else.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality. As I previously stated, where I live and work is rural, and these people have enough incomplete or inaccurate information to sort through. Someone showing up on their doorstep will only exacerbate this issue and frustrate an already marginalized group.

- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.

- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.

- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.

- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.

- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.

- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.

- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.

- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.

- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

• **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to “make their best guess” regarding income. This “guess” can be complex for the self-employed consumers.
- O The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
- O The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. o The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
- O If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
- O I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
- O I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• **Section 155.220(j)(2)(ii)(A)**

- O I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
- O I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
- O An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• **Section 155.220(j)(2)(ii)(A)(1)**

- O To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
- O I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professional hold myself to the highest regard of integrity.
- O I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
- O Please keep in mind, many consumers do not have access to computers, most have access to phones.
- O With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• **Section 155.220(j)(2)(ii)(B)**

- O This section is speaking about an issue that is happening across the nation to many professionals.
- O I know colleagues who have had a “rouge” agent steal their clients.
- O Currently, we are required to report this individual, the client is willing to file suit, however,

we are not aware of agents being removed from the FFM system.

O This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.

O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.

O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?

O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.

O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Larry Keith Groh

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Service.

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great states of Texas. My role here is to support agents and clients in their understanding of the ever-changing requirements and benefits that come from utilizing the options provided by the Marketplace.

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
 - Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
 - Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.

- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- Providing Correct Information to the FFs (Section 155.220 (j))

- O I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.

- O As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.

- O This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.

- O I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.

- O Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.

- O I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**

- O I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.

- O Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.

- O I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

- **Section 155.220(j)(2)(ii)**

- O I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess"

regarding income. This “guess” can be complex for the self-employed consumers.

- The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.

- The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. ○ The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.

- If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.

- I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.

- I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

• Section 155.220(j)(2)(ii)(A)

- I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.

- I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.

- An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information

• Section 155.220(j)(2)(ii)(A)(1)

- To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.

- I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.

- I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.

- Please keep in mind, many consumers do not have access to computers, most have access to phones.

- With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

• Section 155.220(j)(2)(ii)(B)

- This section is speaking about an issue that is happening across the nation to many professionals.

- I know colleagues who have had a “rouge” agent steal their clients.

- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.

- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.

- O Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
- O When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- O Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- O We need help in this area but requiring additional paperwork doesn't seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

Danielle Elyse Martz



(304) 897-5915
FAX (304) 897-6216
PO Box 97
Baker, WV 26801

January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

E.A. Hawse Health Center, Inc. is an FQHC located in the Eastern Panhandle of WV. We serve over 19,000 patients (more than 1/3 of the population in our service area) with three pharmacies, Primary Care, Pediatrics, Chiropractic, Behavioral Health, Women's Health (GYN), Diabetic Educators, Registered Dietician, School Based Health and Behavioral Health. We have seven clinic locations in three counties. We provide a sliding fee and copayment assistance for uninsured/underinsured patients as well as several programs aimed at children such as a food pantry at one school and backpack meals sent home on weekends with children that rely on school based lunch programs for nutrition.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced cost coverage through Federal and State marketplaces. Roughly 40% of our patient mix are Medicaid subscribers with Medicare and Private insurance evenly split at 30% each. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, E.A. Hawse Health Center FQHCs helped nearly 2,500 individuals seeking coverage in 2021. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. OUR ORGANIZATION strongly appreciates that many of these proposed changes, especially related to outreach and enrollment

Accessible Affordable Quality Care Since

and Marketplace protections, build upon the Administration’s proposed changes in the proposed rule “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

E.A. Hawse Health Center welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

Hawse Health Center supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. **Hawse Health Center** recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, Hawse Health Center recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals.” As OUR ORGANIZATION has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. **Hawse Health Center** recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to

¹ Section 1311(c)(1)(C)

participate in the plan's provider network for the respective QHP certification plan year, where an ECP in that category is available..."² but given the crucial role health centers play in delivering primary care services, **Hawse Health Center** believes that these good-faith contracts should extend to all FQHCs in their service area.

Hawse Health Center recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like **Hawse Health Center** to engage with states and hold them accountable. **Hawse Health Center** recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as "those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,"⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and COVID-19 vaccination efforts. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

E.A. Hawse Health Center strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ Section 1902(bb) of the Social Security Act

⁴ [https://www.cms.gov/files/document/ecp-listing-cover-sheet-](https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.)

[03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.](https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.)

Accessible Affordable Quality Care Since

and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. **E.A. Hawse Health Center** appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. **E.A. Hawse Health Center** appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

E.A. Hawse Health Center also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

E.A. Hawse Health Center also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20growth,trillion%20or%20%2412%2C530%20per%20person.>

⁶ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1.>

less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

E.A. Hawse Health Center appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

Hawse Health Center is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. 150,000 people are anticipated to receive redeterminations. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, E.A. Hawse Health Center hopes they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. E.A. Hawse Health Center also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

E.A. Hawse Health Center supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

E.A. Hawse Health Center supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, **E.A. Hawse Health Center** applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and **E.A. Hawse Health Center** also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. **E.A. Hawse Health Center** appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

E.A. Hawse Health Center also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OUR ORGANIZATION appreciates CMS recognizing how administrative functions can impact continuity of

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

E.A. Hawse Health Center recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection E.A. Hawse Health Center supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact: Charlie Rohrbaugh, RPh COO/Pharmacy Director for E.A. Hawse Health Center, Inc. crohrbaugh@hawsehealth.com 304-897-5915 ext 99676

Sincerely,

Charlie Rohrbaugh, RPh

Accessible Affordable Quality Care Since

PUBLIC SUBMISSION

As of: 1/30/23, 4:49 PM Received: January 28, 2023 Status: Posted Posted: January 30, 2023 Tracking No. ldg-nbqy-vdgf Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0105

Comment on CMS-2022-0192-0003

Submitter Information

Name: Anonymous Anonymous

General Comment

I believe this new rule will put an unnecessary burden on the agents and brokers and would I not recommend it



Elizabeth G. Taylor
Executive Director

Board of Directors

Ann Kappler
Chair
Prudential Financial, Inc.

William B. Schultz
Vice Chair
Zuckerman Spaeder LLP

Miriam Harmatz
Secretary
Florida Health Justice Project

Nick Smirensky, CFA
Treasurer
New York State Health Foundation

L.D. Britt, MD, MPH
Eastern Virginia Medical School

Ian Heath Gershengorn
Jenner & Block

Michele Johnson
Tennessee Justice Center

Arian M. June
Debevoise & Plimpton LLP

Jane Preyer
Environmental Defense Fund (Ret.)

Lourdes A. Rivera
Center for Reproductive Rights

Shamina Sneed
TCW Group, Inc.

Donald B. Verrilli, Jr.
Munger, Tolles & Olson

Stephen Williams
Houston Health Department

Ronald L. Wisor, Jr.
Hogan Lovells

Senior Advisor to the Board
Rep. Henry A. Waxman
Waxman Strategies

General Counsel
Marc Fleischaker
Arent Fox, LLP

January 30, 2023

Submitted via regulations.gov

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-8016

Re: RIN 0938–AU97; CMS–9899–P
Patient Protection and Affordable Care Act;
HHS Notice of Benefit and Payment
Parameters for 2024

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide these comments on the Department of Health and Human Services' (HHS) proposed rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 (hereinafter "NBPP 2024 Proposed Rule").

Please also note our objection to the forty-five day comment period, which is insufficient for such a complex and far-reaching rulemaking. Accordingly, NHeLP's comments herein largely focus on actual regulatory proposals in the NBPP 2024 Proposed Rule, and do not address HHS's various queries on possible future rulemaking.

I. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

A. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

We welcome HHS's proposal to strengthen the Navigator program in the NBPP 2024 Proposed Rule.¹ The Affordable Care Act (ACA) created the Navigator program to provide outreach, assistance and education to consumers seeking health insurance through the ACA Marketplaces. Navigators provide free, unbiased, and comprehensive information about health coverage. Evidence shows that consumers find the process of searching for and keeping health insurance overwhelming, and highly value the assistance they receive from Navigators.²

Evidence also shows that millions of people find the process of applying for and using health insurance overwhelming.³ Many lack basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including Black, Indigenous, and other People of Color (BIPOC).⁴ Navigators also play a key role in enrolling people in Medicaid and the Children's Health Insurance Program (CHIP).

However, despite the vital role Navigators play, the previous administration cut the program. Between 2016 and 2020, program funding was slashed by eighty-four percent and the number of grantees cut in half.⁵ It left at least one state without any navigators and

¹ U.S. Dept. of Health & Human Svcs., *Notice of Benefit and Payment Parameters for 2024 Proposed Rule*, 87 Fed. Reg. 78206-78322 (Dec. 21, 2022), <https://www.govinfo.gov/content/pkg/FR-2022-12-21/pdf/2022-27206.pdf>.

² Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need*, Kaiser Family Foundation (Aug. 7, 2020), <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-rief/>.

³ *Id.*

⁴ Jean Edward et al., *Availability of Health Insurance Literacy Resources Fails to Meet Consumer Needs in Rural, Appalachian Communities: Implications for State Medicaid Waivers*, 37 J. RURAL HEALTH 526, 531-3 (June 25, 2020), <https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12485>; Victor G. Villagram et al., *Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference*, 25 Am. J. Managed Care (Mar. 7, 2019), <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

⁵ Katie Keith, *Marketplace Enrollment Tops 12 Million For 2021; Largest-Ever Funding For Navigators*, Health Affairs Blog (Apr. 22, 2021), <https://www.healthaffairs.org/doi/10.1377/hblog20210422.65513/full/>.

left large regional gaps in other states.⁶ Millions of people looking for assistance with enrollment reported being unable to find help. Several states also reported that funding cuts limited outreach to rural communities and to Black and Latinx populations.⁷ We welcomed HHS's increase in Navigator funding to \$98.9 million for the 2022 plan year.⁸ The investment in the Navigator program has led to record Marketplace enrollment and historic lows in the number of people without insurance.⁹

We have qualified support for HHS's proposal to end the prohibition on door-to-door outreach. Face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of applying, selecting a plan, resolving data matching inconsistencies, and assisting with appeals. In-person assistance is especially critical in rural and underserved communities where people may not have reliable access to a computer or telephone. Door-to-door outreach will bolster efforts to enroll the remaining, hard-to-reach individuals, families, and communities who are eligible for insurance affordability programs, but unenrolled.

Door-to-door outreach underscores the need to ensure that program workers are adequately trained and culturally competent to serve their communities. HHS should also ensure that Navigator programs meet their obligations under federal law to persons with limited English proficiency (LEP) and persons with disabilities.

Allowing Navigators to cold-call prospective enrollees and conduct door-to-door outreach may also help counter brokers, marketers, and fraudsters who engage in direct outreach and steer uninsured persons to junk products like short term, limited duration (STLD) plans and Health Sharing Associations and other health plans and insurance-like products that do not comply with key ACA protections including Essential Health Benefits (EHBs).¹⁰ It may also open the door to identity theft or other criminal acts.

Moreover, we urge HHS to restore the requirement, which it eliminated in the 2019 NBPP Final Rule, to have at least two in-person Navigator organizations in each state and to

⁶ Karen Pollitz & Jennifer Tolbert, *Data Note: Limited Navigator Funding for Federal Marketplace States*, Kaiser Family Found. (Oct. 13, 2020), <https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>.

⁷ Olivia Hoppe & JoAnn Volk, *Affordable Care Act Navigators: Unexpected Success During 2018 Enrollment Season Shouldn't Obscure Challenges Ahead*, Georgetown University Health Policy Institute, Center on Health Insurance Reforms (Jan. 12, 2018).

⁸ U.S. Dept. of Health & Human Srvs., *Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of Healthcare.gov Open Enrollment Period* (Aug. 26, 2022), <https://www.hhs.gov/about/news/2022/08/26/biden-harris-administration-makes-largest-investment-ever-in-navigators-ahead-of-healthcare-gov-open-enrollment-period.html>.

⁹ Ctrs. for Medicare & Medicaid Srvs., *Marketplace 2023 Open Enrollment Period Report: National Snapshot #3* (Jan. 11, 2023), <https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-national-snapshot-3>.

¹⁰ Leukemia and Lymphoma Society (LLS) et al., *Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed* (March 25, 2021), https://www.lls.org/sites/default/files/National/undercovered_report.pdf.

ensure that at least one of those organizations was a trusted community nonprofit.¹¹ Consumer-focused nonprofits are often best positioned to serve as Navigator entities because they are often well-established trusted entities in their local community. They are uniquely positioned to provide outreach to high-need communities in their area.

B. Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

NHeLP strongly supports robust standards and accountability measures for agents, brokers and web-brokers. As a recent report from the Leukemia and Lymphoma Society and approximately thirty other patient advocacy organizations exposed, web brokers often steer consumers to STLD plans, Health Sharing Associations, and other noncompliant plans and products.¹² In fact, a recent Government Accountability Office (GAO) secret shopper report found that in over a quarter of the secret shopper calls, sales representatives attempted to sell non-compliant health coverage and engaged in such misleading and deceptive sales tactics that the GAO referred the sales representative to the Federal Trade Commission for further investigation.¹³

NHeLP supports the proposed changes at § 155.220, which implement new procedures and consumer protection standards for agents, brokers, and web-brokers that assist consumers with enrollments through federal facilitated exchange (FFE) and state-based exchanges that use the federal platform (SBE-FPs). Specifically, we agree with HHS's proposed changes at § 155.220(g)(5)(i)(B) and § 155.220(h)(3) to provide HHS more time to review suspension rebuttal evidence and termination reconsideration requests that agents, brokers, and web-brokers submit to HHS.

We believe it is prudent to allow HHS forty-five calendar days to respond to evidence the agent, broker, or web-broker submits to rebut the allegations that they engaged in fraud or abusive, and sixty calendar days to review cases of agent, broker, or web-broker non-compliance where the license was terminated. These longer timelines will allow HHS sufficient opportunity to adequately review complex inquiries that require more HHS resources and time. Since these are maximum timeframes, HHS could still complete the review of cases that do not involve a large number of alleged violations or impacted consumers in a shorter timeframe.

NHeLP welcomes the proposed changes that require agents, broker, and web-brokers to document that the applicant's eligibility information has been reviewed by, and confirmed to be accurate by, the applicant or their authorized representative, before the application is

¹¹ U.S. Dept. of Health & Human Srvs., Notice of Benefit and Payment Parameters for 2019 Final Rule, 83 Fed. Reg. 16930 – 17070 (April 17, 2018), <https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>.

¹² See LLS, note 10 *supra*.

¹³ U.S. Gov't Accountability Office, *Private Health Coverage: Results of Covert Testing for Selected Offerings*, (Aug. 24, 2020), <https://www.gao.gov/assets/710/709009.pdf>.

submitted. We also support the proposed change that the consumer, or their authorized representative, has to take an action, such as providing a signature or recorded verbal confirmation, to document the consent.

Absent documentation, an agent, broker, or web-broker could fabricate the record and state they received consumer consent when they did not. We also agree that agents, brokers and web-brokers must maintain the verification documentation for a minimum of ten years. This provides HHS sufficient time to audit agents, brokers and web-brokers pursuant to existing § 155.220(c)(5), and make sure they are adhering to these consumer consent requirements. These additional safeguards will help reduce the number of inaccurate eligibility determinations, and the number of consumers who receive the incorrect amount of Advance Premium Tax Credits (APTCs), which in some cases results in high tax liability for the consumer.

Although we agree that HHS should not prescribe the method(s) for agents, brokers, and web-brokers to document the consumer's consent, we do think they should be required to offer consumers multiple different verification options so that the verification process does not unnecessarily exclude consumers from coverage. For example, if an agent only accepts verification by a consumer creating an account and signing through the agent's online portal, but the consumer does not have a computer, this is a barrier to coverage.

HHS should consider expanding the use of consumer consents to protect health care consumers. California's Marketplace, Covered California, requires Covered California Certified Insurance Agents (CIAs) to obtain a Consumer Acknowledgment and Full Disclosure Form from each consumer who purchases a Health Sharing Associations product.¹⁴ The policy requires agents to disclose the consumer's Marketplace enrollment options to them before enrolling them in a Health Sharing Association product, keep a record of the signed form for three years, and disclose the number of Health Sharing Associations sold in the prior year to Covered California.¹⁵ HHS should lift up these best practices and consider requiring agents, brokers and web-brokers selling products through the FFE and SBE-FPs to adhere to these acknowledgment and disclosure requirements.

Overall, NHeLP supports monitoring and oversight of all agents, brokers and web-brokers to ensure they are acting scrupulously and well serving consumers. HHS should confirm that all web-brokers are adhering to approved application questions and flows, providing accurate eligibility assessments (including for Medicaid and CHIP, complex households like those with more than two adults, with mixed immigration status, and American Indians/Alaska Natives), providing appropriate consumer support, displaying all information fully and accurately, and complying with privacy and security standards via regular audits.

¹⁴ Covered Cal., *HCSM Disclosure Forum* (Nov. 2019),

<https://board.coveredca.com/meetings/2019/11-21%20Meeting/Background/HCSM%20Disclosure%20and%20Table.pdf>.

¹⁵ Covered Cal., *HCSM Policy and Procedures 11-12-2019* (Nov. 12, 2019),

<https://board.coveredca.com/meetings/2019/11-21%20Meeting/Background/HCSM%20Policy%20and%20Procedures%2011-12-2019.pdf>.

Additionally, HHS should ensure that agents, brokers and web-brokers follow all non-discrimination requirements, including access for LEP consumers and persons with disabilities.

HHS should also require Marketplaces to provide consumer-friendly tools to curtail agent, broker and web-broker misconduct. For example, on Coveredca.com, a consumer can use the “Insurance Finder” tool to search for Covered California certified agents and enrollers. This allows consumers to feel confident they are working with an agent or certified enroller who has been validated by the Marketplace and who will appropriately guide them to the plan selection process.

C. Failure to File and Reconcile Process (§ 155.305(f)(4))

We agree with HHS’s goal of promoting continuity of coverage, encouraging compliance with the filing and reconciling requirement, minimizing the potential for APTC recipients to incur large tax liabilities over time and avoiding situations where enrollees become uninsured when their APTC is terminated.¹⁶ However, as we have said in previous comments, the Failure to File and Reconcile (FTR) process continues to violate due process requirements of the U.S. Constitution.¹⁷ The FTR process is plagued with deficiencies, including the information provided in the various FTR notices (which should include an explanation of what the FTR requirement is and consequences to coverage), as well as the reliability of the decision-making process.¹⁸ Although we generally support the proposed rule changes regarding FTR, we again request that HHS fix the constitutional deficiencies in the FTR process. In addition, HHS should neither deny nor terminate APTCs due to FTR until those issues are addressed and fully tested.¹⁹

¹⁶ 81 Fed. Reg. 78255.

¹⁷ See, e.g., Nat. Health Law Program, *Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*, 15-17 (Nov. 27, 2017), <https://healthlaw.org/resource/nhelp-comments-on-hhs-2019-proposed-rule-change-to-benefit-payment-parameters/> (describing the due process violations with the FTR notices and processes); see also NHeLP Letters to CCIO regarding the FTR process on Aug. 24, 2017 and Oct. 19, 2017 (on file) [hereinafter “NHeLP FTR Comments”]. Based on the information in the preamble, NHeLP is assuming for these comments that the FTR notices have not changed significantly since we last reviewed and commented on them.

¹⁸ *Id.*

¹⁹ U.S. Const. Amend. XIV; *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314-15 (1950) (requiring “notice reasonably calculated, under all circumstances, to apprise intended parties of the pendency of the action and afford them an opportunity to present their objections” and that “[t]he means [of notice] employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it.”); *Goldberg*, 397 at 267-68 (requiring “timely” notice “detailing the reasons for a proposed action”); *Mathews v. Eldridge*, 424 U.S. 319, 348 (1976) (risk of erroneous deprivation through procedures being used); *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978) (due process requires the assistance program be administered to insure fairness and avoid risk of arbitrary decision making).

HHS highlights the ongoing problems with the reliability and timeliness of the IRS data in determining whether a person is eligible at the time of the determination for APTCs.²⁰ If the Marketplace cannot make an accurate determination of ineligibility based on IRS data because that information is not current or is otherwise unreliable, then the Marketplace must not deny APTCs to individuals on such grounds unless the Marketplace can otherwise check the information from reliable sources before sending termination notices. Moreover, those notices must explain, with specificity, the reasons why that individual is having APTCs terminated such that they can understand the bases of the denial and how to appeal a wrongful termination. It is unconscionable that Marketplace continues to terminate individuals using an error-prone system and in violation of core constitutional protections.

The due process failures of the FTR notices is not a new issue.²¹ The notices we have reviewed do not provide minimally sufficient information for beneficiaries to understand the why the action is being taken, nor do they have the information they need to access a hearing that will afford them the opportunity to explain why the agency's decision is incorrect.²² FTR notices do not include the details needed, including financial calculations and household filing information, for denying APTCs.²³ It is simply constitutionally insufficient to provide a list of three potential reasons for the action, only one of which may be true, or to presume the notice recipient has any understanding of what "failure to reconcile" means.²⁴ This not only leaves the individual guessing as to the reason, it leaves out any relevant financial or tax filer information that may be the reason for the denial.

Predictably, and as HHS has recognized in the preamble to the NBPP 2024 Proposed Rule, this has led to significant confusion from APTC applicants and beneficiaries, not only from the notices but about the requirement overall.²⁵ This confusion also means that people, including those assisted by third-party tax preparers, are likely not accurately answering the application question regarding APTC reconciliation.²⁶ In addition, the problems with data from the IRS, including inaccurate or delayed data, mean that people may have been wrongfully denied their APTCs due to unlawful bad processes. The data cited by HHS regarding the impact of pandemic stays on the FTR process shows how confusing and potentially erroneous the process is, how many people have maintained

²⁰ 87 Fed. Reg. 78255-57.

²¹ NHeLP FTR Comments, *supra* note 17.

²² See, e.g., *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1981) (without adequate notice of reasons for denial "hearing serves no purpose.").

²³ *Goldberg*, 397 U.S. at 267-68 (requiring detailed reasons in notice, including "the legal and factual bases"); see also, e.g., *Barry v. Lyon*, 834 F.3d 706, 720 (6th Cir. 2016) (agency must provide "specific, individualized reasons for the agency action"); *Rodriguez v. Chen*, 985 F. Supp. 1189, 1195 (D. Ariz. 1996) (public interest in assuring health benefits will not be erroneously terminated or denied outweighs inconvenience to the state and the notice must include specific financial information where applicable so that errors may be corrected); *Ortiz v. Eichler*, 616 F. Supp. 1046, 1062 (D. Del. 1985), *aff'd* 794 F.2d 880 (3d Cir. 1986) (requiring notice include what financial information was considered and relevant calculations if calculations of income are involved in the eligibility decision).

²⁴ See, e.g., *Baker v. State*, 191 P.3d 1005, 1010 (Alaska 2008).

²⁵ 87 Fed. Reg. 78255-56.

²⁶ *Id.* at 78256.

coverage, and how important it is to get the process right before beginning to terminate this important benefit again.²⁷

We support the proposed change to only determine an individual ineligible for APTCs after two consecutive tax years due to the delays in filing allowed by IRS and by general delays in IRS information. Requiring two consecutive years will help ensure that people are not terminated for non-filing when they may actually still be within a filing period or because the IRS has not yet processed timely submitted information. The disjointed timing of tax filing and APTC determinations means there would be a high risk of erroneous terminations if the FTR were to continue annually.

We also agree that significantly more outreach is needed not only to beneficiaries, but to tax preparers, about the FTR process and the risk of noncompliance. Understandable and accurate information about the process for determining eligibility is critical.²⁸ The dangers of losing coverage are well documented, as are the impacts of losing APTC coverage and the high risk of not re-enrolling.²⁹

While we support the change to two consecutive years and the delay to restarting the FTR process until the IRS can update its systems and HHS can notify beneficiaries of the change, we further ask that the process not be restarted until HHS can provide a constitutionally sufficient FTR process, including notices. Before FTR is ready to relaunch, HHS must test the data exchanges and decision-making processes to ensure that erroneous decisions are not being made and that the data is accurate, timely, and otherwise reliable. In addition, the notices used throughout the process must properly inform beneficiaries of the process, requirements, bases of any decisions (including any relevant financial or household filing data), and process for requesting an appeal. While we recognize that there is also a need to avoid individuals from accumulating significant tax liability, we believe interim processes can be implemented to notify people of the FTR requirement, processes, and consequences.

D. Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

Applicants and enrollees renewing their coverage can encounter difficulties when their projected annual household income is inconsistent IRS data or when that data is unavailable. HHS now recognizes that, when seeking to resolve data matching issues (DMI), “[t]he current process is overly punitive to consumers and burdensome to

²⁷ 87 Fed Reg. 78256-57.

²⁸ See, e.g., *Goldberg*, 397 U.S. at 267-68; *Goss v. Lopez*, 419 U.S. 565, 579 (1975) (due process has little reality or worth unless a person understands the issue is pending); see also *Waldrop v. New Mexico Dept. Hum. Servs. Dep’t*, No. CV 14-047 JH/KBM, 2015 WL 13665460, at *24 (D.N.M. Mar. 10, 2015) (beneficiary must be provided notice about the process).

²⁹ 87 Fed Reg. 78256-57.

Exchanges.”³⁰ We agree. The lag time in IRS data, plus requiring consumers to document income not yet received, has led some consumers to give up and forgo coverage.

Accordingly, we support HHS’s proposal to require Marketplaces to accept an applicant’s or enrollee’s attestation of projected annual household income when the Marketplace requests IRS tax return data, but IRS confirms such data is not available. We also support HHS’s proposal to provide those with DMI additional time to provide documentation. We recognize that consumers may be stymied by the process to resolve their inconsistencies. This is due to systems issues, faulty notices, and a lack of receipt of notices. The result is that many consumers who have DMIs believe they have sent in sufficient documents to resolve their DMI only to find out after the end of the DMI reasonable opportunity period that they actually did not resolve the DMI and instead have had their APTCs reduced or terminated.

The impact of the faulty DMI resolution process has left many consumers responsible for paying the full premiums to their issuer after the end of the inconsistency period and during the appeal process, which often takes longer than ninety days. For consumers determined initially eligible for APTCs, this can create an extreme financial hardship and puts these consumers in a bind of maintaining coverage with full premiums versus losing coverage and possibly suffering financial hardship if they incur medical expenses or an individual responsibility payment if coverage lapses for more than three months.

While an appeal resolution can provide retroactive coverage, this is of little comfort to consumers experiencing financial burdens during the appeal period. The appeals process often takes longer for many consumers expect, extending the time period for which they have to pay full premiums to maintain coverage or remain uninsured and at risk of incurring significant medical costs if an emergency arises or they have an ongoing or chronic condition needing treatment.

E. Annual Eligibility Redetermination (§ 155.335)

Selecting a health insurance plan is complicated, and many people, regardless of education level, find it difficult to make a choice and often do not change their choice once it is made.³¹ Studies show that people routinely pick plans that are not the most beneficial.³² In one study, only five percent of people did better at choosing an ideal plan than they would have by choosing a plan at random.³³ That same study found that if

³⁰ 87 Fed. Reg. 78257.

³¹ Margot Sanger-Katz, *It’s Not Just You: Picking a Health Insurance Plan is Really Hard*, N.Y. TIMES (Dec. 11, 2020), <https://www.nytimes.com/2020/12/11/upshot/choosing-health-insurance-is-hard.html>; Saurabh Bhargava et al., *Choose to Lose: Health Plan Choices form a Menu with Dominated Options*, Q. J. ECONS. 1319, 1323 (Apr. 27, 2017), <https://www.cmu.edu/dietrich/sds/docs/loewenstein/ChoseLose.pdf>.

³² *Id.*

³³ See Benjamin R. Handel et al., *The Social Determinants of Choice Quality: Evidence from Health Insurance in the Netherlands*, NAT’L BUREAU OF ECON. RSCH. 4 (Sept. 2020),

individuals with lower socioeconomic status (and in particular, individuals with less education), are less likely to make complex decisions.

We recognize a default process for auto-reenrolling consumers is necessary, as some consumers will not actively return to the Marketplace to make plan choices during open enrollment. We also agree that the current default re-enrollment hierarchy sometimes encourages consumers to remain in plans that are significantly more expensive than the lowest-cost plans available.

We commend HHS for continuing to improve the re-enrollment process to better serve consumers' interests. We support the new re-enrollment hierarchy for enrollees who would otherwise be automatically reenrolled in a bronze-level Qualified Health Plan (QHP) without Cost Sharing Reductions (CSRs), to instead be automatically reenrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium.

Researchers found that in Covered California's 2018 market, fully thirty percent of households whose coverage was automatically renewed were certain to be better off in a different plan. On average, families were charged an extra \$466 a year in annual premiums by remaining with a plan that no longer served their interests.³⁴

Our experience working with Navigators and other enrollment assisters confirms that affordability continues to drive consumer concerns. However, we have also observed increased consumer recognition of the importance of continuity of providers and covered services and cost-sharing structure. We appreciate HHS's challenge in devising a reenrollment methodology prioritizes affordability, while considering continuity of coverage, and providers, and also encouraging consumers to play an active role in regularly evaluating and choosing their plan.

Our experience shows that consumers rarely prioritize continuity of issuer. Consumers care about their providers, coverage of services they use, and cost-sharing policies. While some

https://www.nber.org/system/files/working_papers/w27785/w27785.pdf; see also Jonathan Gruber et al., *Managing Intelligence: Skilled Experts and AI in Markets for Complex Products*, NAT'L BUREAU OF ECON. RSCH. (Apr. 2020), https://www.nber.org/system/files/working_papers/w27038/w27038.pdf (finding that an algorithm has better outcomes than professionals trained to help people select plans when the decisions are financial). Although the Handel study is based in the Netherlands, the authors explicitly connected the findings to U.S. Marketplace choices. The study found that individuals with lower education and income chose higher deductible plans, calling into question the theory that people will choose to engage in activities to lower deductibles or cost-sharing. Other studies have found that even when other influences on plan choice are controlled for and the only choices are financial, people make harmful financial choices because health insurance is difficult to understand. See, e.g., Bhargava, *supra* note 31. The same study challenged the standard practice of inferring risk preferences from consumer insurance choices. *Id.*

³⁴ Petra W. Rasmussen & David Anderson, *When All That Glitters is Gold: Dominated Plan Choice on Covered California for the 2018 Plan Year*, MILBANK Q. (Dec. 2021), <https://www.milbank.org/quarterly/articles/when-all-that-glitters-is-gold-dominated-plan-choice-on-covered-california-for-the-2018-plan-year/>.

correlation may exist between continuity of issuers and providers/policies, this is not always the case. Therefore, we do not support an approach that prioritizes continuity of issuer, as the network and policies of a “similar” issuer plan may create a false sense of continuity. Instead, we believe continuity should be measured by providers, cost-sharing structure, and coverage policies, with continuity of primary care provider (PCP) being the simplest proxy for provider continuity (and recognizing that for some consumers, a primary care provider may indeed be a specialist such as women whose gynecologist serves as a PCP or individuals with disabilities who may have a specialist providing the primary source of care).

Ultimately, for consumers who do not shop at all during open enrollment, the vast majority care more about cost than carrier or provider network. Accordingly, we recommend that HHS prioritize in the default reenrollment hierarchy that when the consumer’s former plan is no longer offered, auto-enrolling the consumer in the most generous plan that that is closest to the former plan.

The notice informing the consumer of the change in plan should let the consumer opt out of the change by selecting a different plan, chosen based on the current reenrollment hierarchy, or by terminating coverage altogether. However, the default assignment, in case of complete consumer inaction, should prioritize affordability, rather than continuity of carrier and product line.

F. Special Enrollment Periods (§ 155.420)

We support the proposed changes at § 155.420(a)(4)(ii)(A) and (B). These are technical changes to clarify that only one person in a tax household applying for coverage or financial assistance through the Marketplace must qualify for a special enrollment period (SEP) under paragraphs (d)(6)(i) and (ii) in order for the entire household to qualify for the SEP.

1. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

NHeLP strongly supports the proposed change at § 155.420(b), which will give Marketplaces the option to offer earlier coverage effective start dates for consumers with a future loss of minimum essential coverage (MEC). This will help individuals who lose non-Marketplace coverage mid-month avoid a gap in coverage before their Marketplace coverage is effectuated. This will certainly help individuals in states who terminate Medicaid and CHIP coverage mid-month. This proposed change will be particularly helpful in light of the large volume of transitions anticipated from Medicaid/CHIP coverage to Marketplace coverage at the end of the Medicaid continuous coverage requirement.

This proposed change will provide expedient access to Marketplace coverage and financial assistance so that consumers can get the care they need. When consumers have gaps in health insurance coverage, health care utilization declines, which can lead to poorer health

outcomes. Gaps in health care coverage result in increased non-adherence in the treatment of potentially serious medical conditions.³⁵ For example, treatment gaps can have deadly consequences for some, including people living with HIV/AIDS where “even short interruptions of care can threaten health and undermine prevention effects.”³⁶ Coverage gaps exacerbate ongoing racial and ethnic disparities in treatment adherence for persons with chronic conditions.³⁷

This proposed change will help consumers avoid the difficult decision between paying out of pocket for medically necessary care when they are uninsured and foregoing care that could negatively impact their health.

Given that this proposed change may result in some consumers having overlapping coverage for part of a single month, we recommend that Marketplace give the consumer the option of the earlier or later Marketplace start date. Some consumers may opt for the later start date due to complexities of overlapping coverage and ongoing medical needs.

2. Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

Under current rules, the loss of MEC triggers a sixty day special enrollment period (SEP) in which an individual can enroll in a Marketplace plan.³⁸ However, as HHS notes, sixty days after Medicaid termination, enrollees could still be attempting to establish Medicaid eligibility, and they could miss the opportunity to enroll in Marketplace plans with APTC.³⁹

NHeLP supports extending the sixty-day SEP resulting from loss of Medicaid or CHIP to ninety days. The SEP change can help to mitigate gaps in coverage during the unwinding of the Public Health Emergency (PHE).

However, we disagree with HHS’s proposal to make the ninety-day SEP optional. First, we note that federal rules already provide Marketplaces broad authority to grant SEPs under “exceptional circumstances.”⁴⁰ Second, the ninety-day alignment between Marketplace rules for loss of Medicaid and CHIP, and the Medicaid/CHIP ninety-day reconsideration period, should be mandatory, not optional. Finally, we object to delaying implementation of

³⁵ See, e.g., Laura E. Happe et al., *A systematic literature review assessing the direction impact of managed care formulary restrictions on medication adherence, clinical outcomes, economic outcomes, and health care resources utilization*, J MANAG CARE SPEC PHARM; 207):67-84 (2014); Dr. C. Daniel Mullins et al., *Persistence, switching, and discontinuation rates among patients receiving sertraline, paroxetine, and citalopram*, PHARMACOTHERAPY 25-660-7 (2005).

³⁶ Dana P. Goldman et al., *The Prospect Of A Generation Free Of HIV May Be Within Reach If The Right Policy Decisions Are Made*, 33 HEALTH AFFAIRS, 430 (2014).

³⁷ Zhiwen Xie et al., *Racial and ethnic disparities in medication adherence among privately insured patients in the United States*, PLOS ONE (Feb. 14, 2019), <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0212117&type=printable>.

³⁸ 45 C.F.R. § 155.420(c)(1).

³⁹ See 42 C.F.R. 42 C.F.R. § 435.916(a)(3)(iii), allowing Medicaid enrollees a ninety-day reconsideration period to correct any erroneous information and re-establish Medicaid eligibility

⁴⁰ 45 C.F.R. § 155.420(d)(9).

the extended SEP to January 2024. Now that the Consolidated Appropriations Act, 2022 has delinked the continuous coverage policy from the PHE and stated that eligibility redeterminations can begin again on April 1, 2023, millions of Medicaid and CHIP enrollees could face termination much sooner than January 2024.

3. Plan Display Error Special Enrollment Periods (§ 155.420(d))

We support HHS's proposal to provide a SEP to consumers who encounter a material error related to plan benefits, service area, cost-sharing, or premium. While it is important to protect consumers from the consequences of material errors that influence plan selection, HHS should take all necessary steps to prevent such errors from happening in the first place.

G. General Eligibility Appeals - Requirements (§ 155.505)

HHS clarifies the timeline for eligibility appeals and authority of the CMS Administrator to review Marketplace eligibility appeals decisions prior to judicial review. We recognize the ACA confers authority not only establish appeals processes, but that the HHS Secretary also "hears and makes decisions with respect to appeals."⁴¹

HHS should make every effort to ensure that right decision is made at the lowest level of review.

II. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

A. FFE and SBE–FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

User fees are essential to operate the Marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. Over the years, we have identified a number of issues that HHS should address throughout HealthCare.gov. These include enhancing the consumer experience through improvements to the application and healthcare.gov as well as addressing other behind-the-scenes issues.⁴² We believe HHS should maintain the current user fees until it completes much needed fixes and enhancements.

⁴¹ See 42 U.S.C. § 18081(f)(1)(A).

⁴² For example, HHS should create a dashboard for navigators and assisters to better track their clients; establish linkages between healthcare.gov and the appeals unit so the appeals unit has ready access to documents consumers have provided and also effectuate appeals; and provide the call center ready access to any documents submitted by the consumer to resolve a DMI.

B. Standardized Plan Options (§ 156.201)

Plans that share a common benefits structure, including tiering and cost-sharing, allow consumers to make apples-to-apples comparisons of plans and benefits. NHeLP strongly supports HHS's efforts to require issuers in the FFE and SBE-FPs to offer at least one standardized plan at every product network type, metal level, and in every service area where the issuer also offers non-standardized plans.

A recent Assistant Secretary for Planning and Evaluation (ASPE) issue brief indicates that “almost three quarters of *HealthCare.gov* consumers have *more than 60 plan options* to choose from, and the average number of plans is *over 100*” (emphasis added).⁴³ Because health care is not a typical consumer good, the usual understanding that more is better for the consumer does not hold true in the Marketplace. On the contrary, the high number of plan options often leads to confusion among shoppers, which in turn gives way to consumer errors during plan selection. As the ASPE reports finds, a higher number of plan options runs counter to the central premise of the ACA, which relies on plan competition to increase the value of health care and requires informed consumers to “select among competing plans to realize that value.”⁴⁴ Choice overload, on the other hand, often leads consumers to make selections without regard to value and discourages consumers from switching from lower-value plans to higher-value plans.

While HHS's proposal does not directly limit the number of plan options available to consumers in the Marketplace, it will nonetheless enable consumers to make apples-to-apples comparisons of plans sharing a common benefit and cost-sharing structure. The ACA generally achieved common benefit structure across plans through the requirement that Marketplace plans cover EHB, but lack of cost-sharing standardization has allowed issuers to offer an unlimited number of plans. Through the standardization proposal, consumers could compare plans without regards to cost-sharing requirements, allowing individuals to focus on other factors that are better indicators of the plan's value and that are more crucial to consumers' health, such as premiums, provider network, and quality of services.

Standardization also serves as a tool to improve affordability and address health disparities in the Marketplace. HHS's proposal will ensure that consumers always have access to at least one plan that exempts certain essential services, including emergency room services, primary care visits, and mental health and substance use disorder treatment, from deductibles. Because people of color and other underserved populations often lack access to such services that are key to prevent further health complications, exempting these

⁴³ U.S. Dept. of Health & Human Servs., Assistant Sec'y for Plan. and Evaluation (“ASPE”), *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 1 (2021), <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

⁴⁴ *Id.* at 4.

services from the deductible in all standardized plans will make it easier for these communities to receive the care they need and help close gaps in access to care.⁴⁵

The effectiveness of standardization in improving access and affordability is evident by the experience of the nine states and the District of Columbia that have already adopted standardization in their state-run Marketplaces. In particular, our experience as consumer advocates in California, the only state that requires *all* plans in the Marketplace to be standardized, solidifies our support for HHS' standardization proposal. California has required all plans to be standardized since Covered California's inception in 2014. The result of this policy has been that consumers are able to navigate the Marketplace and shop around without having to worry about price variation within particular tiers and service areas. In turn, this ease of access has led to robust coverage across all counties in California alongside significant, albeit incomplete, improvements in the quality of care provided due to competition being based on plans' overall value instead of cost.

Despite our strong support for the standardization proposal, we are concerned that some of the cost-sharing in standardized plans remains too high and unaffordable for beneficiaries with high needs. To improve affordability of drugs used to treat people with disabilities and those with chronic conditions, we recommend that HHS exempt them from deductible requirements across silver plans, which represent the bulk of enrollment in the Marketplace. In addition, copays for specialty drugs remain too high and unaffordable for most individuals. As such, we urge HHS to evaluate the possibility of lowering copayments for "specialty" drugs without the need to increase cost-sharing for other services pursuant to the AV calculator.

We further urge HHS to prohibit coinsurance, which is inherently discriminatory and unduly shifts the costs of care to persons with high health needs. Coinsurance also increases confusion among consumers because even more experienced consumers may fail to understand that a lower coinsurance percentage may nonetheless represent a higher out-of-pocket amount than copayments. Coinsurance is particularly invidious for prescription drugs, for which actual prices vary considerably. Consumers are ill-equipped to consider these price variations and plans do not provide information on the dollar amount of coinsurance a consumer can expect to be charged.

⁴⁵ For a discussion about how issuers use benefit manipulation and "adverse tiering" to discriminate against individuals with high-cost needs and how standardization helps fix this problem, see Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFF. (2016), <https://www.healthaffairs.org/doi/10.1377/forefront.20160106.052546>.

C. Non-Standardized Plan Option Limits (§ 156.202)

In recent years, there has been a sharp increase in the number of plans available to consumers. In 2019, in the FFE and SBE-FPs, an average of 27.1 plans were available per enrollee.⁴⁶ This number climbed to 109.2 plans per enrollee in 2022.⁴⁷

A recent RAND Corporation study shows that when consumers are given too many plan choices, there is the greater potential to make poor enrollment decisions. Multiple factors result in less than optimal plan choice decision making, including but not limited to the challenge of processing complex health plan information, inadequate decision support tools, and low health literacy and numeracy.⁴⁸ Consumers may incorrectly calculate costs, or focus on premiums without even considering total out-of-pocket costs. When there are too many options, consumers may also be susceptible to how choices are presented on the website. For example, someone might select a plan merely because it is presented first on the website. Of most concern, consumers may experience decision fatigue and not enroll in health insurance at all.

In an effort to simplify the plan choice decision-making process, NHeLP supports HHS's proposal to establish a numeric limit on the availability of non-standardized plans. However, we urge HHS to also require a meaningful difference in the plans offered, by reinstating the standard previously codified at 45 C.F.R. § 156.298. This would limit the volume of nearly similar plans so that consumers can readily compare plan, and also ensure that consumers have real choices when selecting a plan.

In addition to limiting plan selection, the evidence shows that outreach efforts help optimize plan selection and help consumers avoid choice errors. A Covered California analysis found that nearly 20,000 Covered California consumers selected more expensive gold and platinum plans in 2019 despite being eligible for a less expensive enhanced silver plan with richer benefits.⁴⁹ Covered California sent additional emails and letters to these consumers describing the financial savings if they switched to the silver product, and as a result, roughly twenty percent of these individuals switched to a silver plan with a lower premium and cost-sharing savings.⁵⁰ This analysis clarifies that consumers make suboptimal plan selections simply because of the sheer number of plans to choose from, and the complexity of information on Marketplace platforms. HHS should require Marketplaces to implement a

⁴⁶ U.S. Dept. of Health & Human Srvs., Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584, 690 (Jan. 5, 2022) <https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf>.

⁴⁷ *Id.*

⁴⁸ Erin Audrey Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace*, RAND Corp. (2016), https://www.rand.org/pubs/research_reports/RR1567.html.

⁴⁹ Andrew Feher & Isaac Menashe, *Using Email and Letters To Reduce Choice Errors Among ACA Marketplace Enrollees*, Health Affs. 812, 814 (May 2021), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02099>

⁵⁰ *Id.* at 815.

multi-pronged approach to helping consumers navigate the platforms to make sound plan selections.

D. Network Adequacy (§ 156.230)

NHeLP commends HHS's decision to amend §§ 156.230 and 156.235 to clarify that only plans that use networks may participate in the Marketplace. NHeLP has long raised concerns about people's ability to access care and control their health care costs in non-network plan models. The decision to allow only network model plans to participate, based on HHS's experience that few non-network plans have participated in the Marketplace in fact, and that it is difficult for HHS to ensure that enrollees in those plans have adequate access to care, is extremely sensible. We are not aware of any regulatory standards that evaluate whether a non-network plan offers a sufficient selection of providers without excessive burden on its members.⁵¹

NHeLP agrees with HHS's assumption that most people prefer plans, including Stand Alone Dental Plans (SADPs), that use a network, since it is easier for them to understand which providers are covered under their plan. Furthermore, over the last several years, the market has become more and more dominated by network plans.⁵² While non-network plans are more common for SADPs than for health plans, they are still increasingly rare.⁵³ In any event, given the inherent difficulty in ensuring that non-network plans provide enrollees with adequate access to care without undue burden, we support the proposed change.

In addition, NHeLP urges HHS to take additional action to ensure that QHPs are complying with existing network adequacy standards. We appreciate the work HHS has done to ensure that QHPs are subject to robust network adequacy standards so that they are able to make covered services available to their enrollees. Despite these standards, reports

⁵¹ We note that California's Department of Insurance has issued adequacy and access standards that apply across licensed health care products, including both network plans (such as PPOs) and traditional indemnity plans. See Cal. Dep't Ins., Provider Network Adequacy, <http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm> (last visited Jan. 10, 2023). While these standards account for the selection of providers, they do not measure the burden on members, and thus we cannot recommend them to HHS. We also note, however, that traditional indemnity plans make up an increasingly small portion of the insurance market in California, as in other jurisdictions. See, e.g., Gary Claxton et al., Kaiser Family Found. & Health Res. & Ed. Trust, *Employer Health Benefits: 2016 Survey* at 76 (2017), <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey> (less than 1% of people enrolled in employer-sponsored insurance nationally were enrolled in a non-network plan in 2016).

⁵² See Claxton et al., *supra* note 54 at 71-76; see also Christen Linke Young & Kathleen Hannick, USC-BROOKINGS SCHAEFFER, *Fixed Indemnity Health Coverage is a Problematic Form of "Junk Insurance"* (Aug. 4, 2020), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

⁵³ See, e.g. Avery Smith, DentalInsurance.com, *Indemnity Dental Insurance* (Dec. 14, 2022) (estimating that indemnity plans comprised 6% of the dental insurance market in 2022), <https://www.dentalinsurance.com/resources/dental-plans/indemnity-dental-insurance>.

abound of network adequacy issues in QHPs, particularly regarding access to behavioral health services.⁵⁴ Thus, vigorous enforcement is needed to ensure that QHPs' networks are sufficient to provide access to covered services.

E. Essential Community Providers (§ 156.235)

Essential Community Providers (ECPs) provide care to predominately low-income and medically underserved populations, and are important to improving health outcomes and advancing health equity.⁵⁵ BIPOC people face significant barriers in access to and utilization of care.⁵⁶ Nonelderly BIPOC individuals face increased barriers to accessing care compared to whites and have lower utilization of care. For example, preterm birth rate for Black people is fifty-one percent higher than the rate among people of other races, and Black people also experience higher rates of certain chronic conditions such as diabetes, hypertension, and sexually transmitted infections, which can result in poor birth outcomes if unidentified or unmanaged before pregnancy.⁵⁷ Increasing ECP participation in QHPs is an important step toward addressing these disparities.

1. Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers

HHS proposes to add Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers as stand-alone ECP categories beginning in FY 2024. We support this proposal.

Millions of people in the United States have a behavioral health condition, but do not receive the care they need. More than one in five adults (57.8 million people) have a mental health condition, while an estimated 46.3 million adolescents and adults live with a SUD.⁵⁸ Despite the prevalence of these conditions, people with behavioral health conditions struggle to find care. Over half of people with a mental health condition did not receive any care.⁵⁹ Only 6.3% of individuals ages twelve or older who needed SUD treatment in the past year received it.⁶⁰

⁵⁴ See, e.g., Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39 HEALTH AFF. 975 (2020).

⁵⁵ Cristina Jade Peña et. al., Kaiser Family Found., *Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health* (2015), <http://files.kff.org/attachment/issue-brief-federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health>.

⁵⁶ Samantha Artiga & Kendal Orgera, Kaiser Family Found., *Key Facts on Health and Health Care by Race and Ethnicity* (2019), <https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-coverage-access-to-and-use-of-care>.

⁵⁷ March of Dimes, *2021 March of Dimes Report Card 2* (2021), https://www.marchofdimes.org/materials/March_of_Dimes_US_2021_Report_Card_11152021.pdf.

⁵⁸ Substance Abuse & Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* 39, 46 (2022), <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf>

⁵⁹ *Id.* at 58.

⁶⁰ *Id.* at 51.

The unmet need for mental health services is particularly serious among groups that have historically experienced discrimination. For example, African Americans, American Indians, and Alaska Natives access mental health services at substantially lower rates than white Americans.⁶¹ The COVID-19 pandemic has had significant impacts on behavioral health, with sharp increases in the prevalence of conditions in specific populations, such as young adults, people of color, essential workers, and unpaid caregivers, experiencing a disproportionate impact.⁶²

Studies repeatedly demonstrate that people with behavioral health conditions who have insurance encounter difficulty locating, receiving, and affording care.⁶³ In particular, people with behavioral health conditions report difficulties finding in-network providers that are taking new patients.⁶⁴ As a result, some people delay or forego care entirely, while others seek out-of-network care, at far higher costs.⁶⁵ Given all of this, we support HHS's proposal to create standalone categories for SUD Treatment Centers and Mental Health Facilities as stand-alone ECP categories for improving access to care among low-income and medically underserved populations.

We also support the proposal to crosswalk the Community Mental Health Center (CMHC) provider type into the newly created Mental Health Facilities category. However, as currently written, HHS defines Mental Health Facilities as CMHCs and "other mental health providers."⁶⁶ While we support including other mental health providers in the definition of a "Mental Health Facility," it would be helpful to further define what other types of providers beyond CMHCs might fall in the ECP Mental Health Facilities Category. HHS may want to limit providers to those that are subject to some additional conditions of participation or other indicia of quality. This could help ensure that plans contract with facilities that provide

⁶¹ Azza Altiraifi & Nicole Rapfogel, Ctr. for Am. Progress, *Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis* (Sept 10, 2020), <https://www.americanprogress.org/article/mental-health-care-severely-inequitable-came-coronavirus-crisis/>.

⁶² Ctrs. for Disease Control & Prevention, *Morbidity and Mortality Weekly Report: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020* (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf>.

⁶³ See, e.g., Nat'l All. on Mental Illness, *The Doctor is Out: Continuing Disparities in Mental Health Care* (2017), <https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut>; Nat'l All. on Mental Illness, *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity* (2016), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf;

⁶⁴ Steve Melek et al., Milliman, *Milliman Research Report: Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (2019), https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

⁶⁵ *Id.* See also, Nicole M. Benson & Zirui Song, *Prices and Cost-Sharing In-Network vs. Out-of-Network for Behavioral Health, 2007-2017* 39 HEALTH AFF. 1210-1218 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8128060/#R1>.

⁶⁶ 87 Fed. Reg. 78290.

some basic level of services, that adhere to patient rights protections, and that provide services in the least restrictive setting appropriate.

Similarly, we urge HHS to further define what types of treatment facilities can fall into the SUD Treatment Center category. Given how widespread ineffective and low-quality SUD providers are, we especially note that it is important that HHS not allow QHPs to fulfil their obligations in this area by contracting with low-quality providers.⁶⁷ At a minimum, this means that SUD providers should be able to provide onsite, or refer patients to Medication Assisted Treatment (MAT). In addition, QHPs should be responsible for periodically reporting access and quality information that enables HHS and states to identify which SUD services are being utilized and for which services gaps remain, as well as information about demographics and access data to address potential health disparities in access to SUD care.

2. Family Planning Providers and Federally Qualified Health Centers

HHS proposes that for PY (Plan Year) 2024 and beyond, QHPs must contract with at least thirty-five percent of available Federally Qualified Health Centers (FQHCs) and at least thirty-five percent of available Family Planning Providers that qualify as ECPs in the plan's service area. These requirements would be in addition to the existing provider participation requirement, which states that QHPs must contract with thirty five percent of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the thirty-five percent threshold.

We support this proposal, which will help ensure that QHP enrollees, especially those who have low-incomes and those who are BIPOC, have full access to these important benefits. However, we remain concerned that HHS continues to relegate the ECP threshold setting to sub-regulatory action. Given the ongoing attacks on health care access, especially reproductive health, we urge HHS to codify the ECP thresholds in regulation.

Accordingly, we urge HHS to amend the regulatory text to require QHPs to include thirty-five percent of available ECPs in their networks. We continue to support HHS's decision to treat multiple providers at a single location as one ECP, and to require QHPs with tiered networks to meet the ECP threshold in the lowest cost-sharing tier.

RECOMMENDATION: We suggest that HHS amend §§ 156.235(a)(2)(i) and (b)(2)(i) as follows:

(a)(2)(i) The QHP issuer's provider network includes as participating providers at least a minimum **35 percentage**, ~~as specified by HHS,~~ of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph

⁶⁷ Brian Mann, *As Addiction Deaths Surge, Profit-Driven Rehab Industry Faces 'Severe Ethical Crisis'*, NPR (Feb. 15, 2021), <https://www.npr.org/2021/02/15/963700736/as-addiction-deaths-surge-profit-driven-rehab-industry-faces-severe-ethical-crisis>.

(ii)(B) of this section, and at least ~~a minimum~~ **35** percentage of available ECPs in each plan's service area within ***the FQHC and Family Planning Provider*** certain individual ECP categories, ~~as specified by HHS.~~

...

(b)(2)(i) (i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies ~~a minimum~~ **35** percentage, ~~specified by HHS,~~ of available essential community providers in the plan's service area ***collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this provision, and satisfies thirty-five (35) percent of available ECPs in each plan's service area within the FQHC and Family Planning Provider ECP categories.***

3. Expanding the "Other ECP Providers" category and clarifying contracting requirements (§ 156.235(a)(2)(ii) & (b)(2)(ii))

We suggest that HHS add the category of "Freestanding Birth Centers" to the Other ECP category, as this is a crucial service for pregnant enrollees. The Strong Start for Mothers and Newborn Initiative, which concluded in 2018, found "significantly improved outcomes" for participants who gave birth at freestanding birth centers (as opposed to receiving care at maternity care homes or group prenatal care).⁶⁸

Moreover, NHeLP understands that there may be rare cases where QHP issuers are not able to reach an agreement with any ECPs in a particular category in a particular region. To address these cases, we support HHS' explicit incorporation of a good faith standard to ensure that QHP issuers have made real efforts to establish contracts with ECPs. We support the language HHS has included in previous guidance specifying that to be considered a good faith offer, a contract must offer rates and contract provisions that a "willing, similarly situated non-ECP provider would accept or has accepted."⁶⁹ We urge HHS to specify that good faith contract terms must include all of the services the plan covers and the ECP provides, and include reimbursement at generally applicable payment rates. We are concerned that without additional specificity, issuers will continue to use a low-reimbursing contract as verification, forcing ECPs into lower reimbursement rate contracts. Without a strong requirement that QHPs make real efforts to establish legal agreements, the overall goal of the guidance will be eroded and QHP issuers will be able to evade the ECP standard by offering ECPs contracts but not following through on them.

⁶⁸ Adam Boehler & Mary C. Mayhew, Ctr. Medicaid & Medicare Servs., *Joint Informational Bulletin: Strong Start for Mothers and Newborns initiative (Strong Start)* (Nov. 9, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf>; see also Embry Howell et al., *Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center*, 4 Medicare & Medicaid Res. Rev. E1 (2014), https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a06.pdf.

⁶⁹ See, e.g., Ctrs. Medicare & Medicaid Servs., *Frequently Asked Questions on Essential Community Providers* 4 (2014), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-on-ECPs-6-12-14.pdf>.

Moreover, HHS should encourage Marketplaces to look closely at any QHP issuer that lacks contracts with ECPs, as that fact alone raises an inference that the issuer's offers have not been made in good faith.

RECOMMENDATION: We suggest that HHS amend § 156.235(a)(2)(ii) and (b)(2)(ii) as follows:

(a)(2)(ii) The issuer of the plan ***makes good faith*** offers ***of*** contracts, ***considering generally applicable payment rates and contract provisions that a willing, similarly situated non-ECP provider with median rates would accept or has accepted,*** to—

...

(B) At least one ECP in each of the eight (8) ECP categories in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type. The ECP categories are: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, and Other ECP Providers. The Other ECP Providers category includes the following types of providers: Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, ~~and Rural Emergency Hospitals,~~ ***Freestanding Birth Centers, and other entities that serve predominantly low-income, medically underserved individuals.***

...

(b)(2)(ii) The issuer's integrated delivery system provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard, or otherwise ***makes good faith*** offers ***of*** a contract, ***considering generally applicable payment rates and contract provisions that a willing, similarly situated non-ECP provider with median rates would accept or has accepted,*** to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area that can provide those services to low-income, medically underserved individuals.

4. ECP write-in option (§ 156.235(a)(3) & (b)(3))

In addition, HHS states that it will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the HHS list of available ECPs. We urge HHS to eliminate this option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard but still have a network that is sufficient to meet the needs of low-income and underserved enrollees. This

provision has the potential to become the exception that swallows the rule. Without an adequate number of ECPs in an issuer's network, people who rely on ECPs for their care will have less access to the care they need. Given the importance of including ECPs in QHP networks, HHS should not provide issuers with leeway to avoid meeting its ECP standards. We recommend that HHS eliminate §§ 156.235(a)(3) and 156.235(b)(3).

5. Other considerations regarding ECPs

We again acknowledge that the tension between provider shortages and the ease of telehealth is very real, particularly in rural communities and for specialized health services. The use of telehealth should not undermine ECP and other access to care protections.

Rather, HHS should encourage QHPs to consider telehealth as another tool in which to improve access while emphasizing that telehealth cannot replace in person health care. We acknowledge that many ECPs including FQHCs and family planning providers have offered critical services during the pandemic using telehealth, but emphasize that ultimately, the modality of service (whether it is telehealth or in-person) must be dictated by the patient's preference and best interests.

We also note here that HHS should ensure that QHP issuers rigorously monitor and enforce ECP participation in their networks. HHS should require QHPs to comply with monitoring and enforcement policies that ensure adequate oversight of QHP networks' compliance with ECP standards throughout the coverage year. We recommend that HHS require issuers to report any material changes to their ECP contracts within thirty days, and ensure that at no time their network falls below the ECP minimum standards. We urge HHS to require Marketplaces to consider access to ECPs in any monitoring and enforcement that it undertakes related to network adequacy as a whole, in addition to monitoring for compliance with ECP standards separately.

F. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

We agree that providing timelines for delinquency notices is important. Without timeliness standards, an individual may not receive timely notice and individuals should not be penalized and potentially lose their coverage because they did not understand what was owed, the deadlines for repayment, or the timeframe of the grace period. If an individual does not receive timely notice of a triggering event—in this case a delinquency—and was reasonably unaware of the delinquency, an issuer should ascribe the date the individual knew or should have known of the triggering event.

Timeliness standards will help avoid situations where consumers do not know of a delinquency until it becomes harder to rectify. Particularly for low-income consumers and those on fixed incomes, accumulating a delinquency over a few months could lead them unable to pay what is needed while a timely notice within a short period of nonpayment may lead them better able to pay what is due.

As we have noted in our comments on previous years' NBPP, terminations of any kind result in a change of circumstances for an enrollee and they must understand the reason for the termination as well as their legal rights to challenge it.⁷⁰ As HHS noted in the 2022 NBPP Final Rule, complaints about terminations are one of the largest sources of casework.⁷¹ Ensuring timely notification about delinquencies and ensuring individuals have sufficient time to address a delinquency, may help address the number of cases needing assistance after a delinquency leads to a termination.

Further, we strongly recommend that HHS require delinquency notices include taglines (including a large print tagline). Individuals with LEP and/or sight issues need to understand the importance of a delinquency notice and how to respond. We believe the regulation should explicitly require taglines because otherwise these individuals will not receive effective notice and could lose their coverage.

We recommend that an insurer send an initial delinquency notice within two calendar weeks of the initial delinquency.

Conclusion

We have included citations and direct links to research and other materials. We request that the full text of material cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these citations part of the record as we have requested, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to comment on these important issues. Please feel free to contact me at (202) 289-7661 or turner@healthlaw.org if you have questions.

Yours truly,

A handwritten signature in dark ink, appearing to read 'W. Turner', followed by a long horizontal flourish.

Wayne Turner
Senior Attorney

⁷⁰ See, e.g., Nat. Health Law Program, *Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* (Dec. 21, 2014), <https://healthlaw.org/resource/nhelp-comments-notice-of-benefit-and-payment-parameters/>.

⁷¹ U.S. Dept. of Health & Human Svcs., *Notice of Benefit and Payment Parameters for 2022 Final Rule*, 86 Fed. Reg. 24239 (May 5, 2021), <https://www.govinfo.gov/content/pkg/FR-2021-05-05/pdf/2021-09102.pdf>.



January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

The National Association of Community Health Centers (NACHC) is the national membership organization for federally qualified health centers (also known as FQHCs or health centers). Health centers are federally-funded or federally-supported nonprofit, community-directed provider clinics that serve as the health home for over 30 million people, including 1 in 5 Medicaid beneficiaries and over 3 million elderly patients. It is the collective mission and mandate of over 1,400 health centers around the country to provide access to high-quality, cost-effective primary and preventative medical care as well as dental, behavioral health, and pharmacy services and other “enabling” or support services that facilitate access to care to individuals and families located in medically underserved areas, regardless of insurance status or ability to pay.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. Twenty-one percent of health center patients have private insurance and 46% of health center patients have Medicaid coverage, some of whom receive coverage through Medicaid expansion.¹ These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, FQHCs helped nearly 4 million individuals seeking coverage in 2021.² This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. NACHC strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration’s proposed changes in the

¹ <https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf>

² <https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=ODE&year=2021>

proposed rule “Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

NACHC welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

NACHC supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)³ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. NACHC recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, NACHC recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As NACHC has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. NACHC recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFM must “offer contracts in good

³ Section 1311(c)(1)(C)

faith to at least one ECP in each ECP category in each county in the service area to participate in the plan's provider network for the respective QHP certification plan year, where an ECP in that category is available..."⁴ but given the crucial role health centers play in delivering primary care services, NACHC believes that these good-faith contracts should extend to all FQHCs in their service area.

NACHC recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate⁵ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like NACHC, to engage with states and hold them accountable. NACHC recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as "those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,"⁶ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

⁴ <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

⁵ Section 1902(bb) of the Social Security Act

⁶ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

II. Reducing Barriers to Enrollment and Financial Assistance

NACHC strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)—to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. NACHC appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. NACHC appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

NACHC also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁷ With the median U.S. household income reported at \$70,784 in 2021,⁸ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing

⁷ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person>.

⁸ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1>).

this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

NACHC also appreciates CMS’ proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁹ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

NACHC appreciates the Administration’s continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.¹⁰ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as “billable providers” and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.¹¹

NACHC is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they

⁹ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

¹⁰ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

¹¹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹² While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹³ this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support for enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, NACHC recommends they remain at their current percentages: 2.5% in the marketplace and 2.25% in the state-based marketplace. NACHC also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health

¹² <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹³ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

insurance is associated with increased access to health services and better health monitoring.^{14 15}

¹⁶ States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

NACHC supports CMS’ proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers’ interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁷ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁸ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

NACHC supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁹ While the majority of Marketplace plans are

¹⁴ Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹⁵ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁶ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

¹⁷ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁸ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁹ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, NACHC applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and NACHC also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. NACHC appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

NACHC also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. NACHC appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

NACHC recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection NACHC supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years.

Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Vacheria Keys, Director of Regulatory Affairs, at vkeys@nachc.org.

Sincerely,

Joe Dunn

Senior Vice President, Public Policy and Research

National Association of Community Health Centers



January 30, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9899-P

To Whom It May Concern:

The Pennsylvania Insurance Department (Department) is pleased to submit the following comments on the HHS Notice of Benefit and Payment Parameters for 2024 Proposed Rule (CMS-9899-P, RIN 0938-AU97) (Proposed 2024 NBPP). The Department appreciates the steps that the Centers for Medicare & Medicaid Services (CMS) propose to take to protect consumers.

Pennsylvania operates Pennie®, its own State-Based Exchange (SBE), so some of the proposed rules would not have a direct impact on Pennsylvania's marketplace. Even so, those proposed rules may establish templates that could serve as models for oversight by SBEs. Comments in the second half of this letter fall into this category.

Proposed Changes That Would Directly Impact State-Based Exchanges.

Re-Enrollment Hierarchies. In a step to assure that consumers are aware of their most favorable coverage opportunity, the proposed rule would amend 45 C.F.R. § 155.335 to allow exchanges, including SBEs, flexibility in their re-enrollment hierarchies. The Department supports this proposal. This proposed rule would allow an exchange to structure its re-enrollment hierarchy to assure that someone who is eligible for cost-sharing reductions (CSRs) would be directed to enrollment in a plan providing those CSRs; that is, to a silver plan rather than a bronze plan. Because silver plans have a greater actuarial value and are the level of plan through which CSRs may be accessed, this would result in a larger number of consumers receiving coverage with more favorable financial impacts than if this proposal were not adopted.

Special Enrollment Periods. The Department appreciates the proposed technical corrections to the Special Enrollment Period (SEP) provision in 45 C.F.R. § 155.420. These technical corrections will, if finalized as proposed, assist families in navigating their coverage options to find the coverage best suited to them after a change in circumstance by any member of the family. The Department also supports the more substantive proposals for 45 C.F.R. § 155.420, both of which would help consumers avoid a gap in coverage, whether through loss of minimum essential coverage or loss of Medicaid or CHIP coverage.

Office of the Insurance Commissioner

1326 Strawberry Square | Harrisburg, Pennsylvania 17120 | Phone: 717.783.0442 | Fax: 717.772.1969
www.insurance.pa.gov | ra-in-commissioner@pa.gov

Network Adequacy. The Department applauds CMS for proposing to require qualified health plans (QHPs) and stand-alone dental plans (SADPs), as well as small business health options program (SHOP) QHPs, where they exist, to use networks that comply with minimum network adequacy and essential community provider (ECP) standards in 45 C.F.R. §§ 156.230 and 156.235. The Department also appreciates the inclusion of “Mental Health Facilities” and “Substance Use Disorder Treatment Centers” as ECP categories in 45 C.F.R. § 156.235(a)(2)(ii)(B).

The Department is currently engaged in a study to evaluate network adequacy for select provider types within the Pennsylvania health insurance market (see [Notice 2022-11](#), 52 Pa.B. 3744 (July 2, 2022)), which heightens its interest in this proposed rule. Having an adequate network of providers is a critical foundation to an insurer’s promise of coverage, and having a consistent standard for what is an adequate network is an important protection for consumers seeking to compare plans.

The Department encourages CMS to consider specifying the applicability of network adequacy criteria to pharmacy access. The Department suggests that consideration be given to assuring that pharmacies be locally available, especially for those in rural communities who rely on independent pharmacists to provide direct pharmaceutical care to their patients. Telemedicine may be able to substitute for an in-person visit to a provider 45 or 60 minutes away, but it cannot obviate the need to travel to get urgently needed medication. The Department encourages CMS to consider using a more stringent adequacy standard for pharmacy services in rural areas to ensure that patients have greater access to care.

Proposed Changes That Would Not Directly Impact State-Based Exchanges.

The Department also offers comment on several proposed revisions that would not be directly applicable to SBEs, but that may offer helpful models for use by those SBEs.

Navigators, Assisters, and Certified Application Counselors. The Proposed 2024 NBPP would facilitate unsolicited door-to-door contacts by navigators, assisters, and certified application counselors (CACs). Navigators, assisters, and CACs are subject to regulatory oversight, so this proposal would not open the door to unscrupulous contacts, but would, rather, open the door to efficient contacts to enable consumers to receive information and receive assistance in navigating the enrollment process during a single visit. This may be an important step toward increasing access for individuals who may not have the ability to shop online or in-person with a local agent, thus lowering the uninsured rate and enrolling people who would be challenged to get out of their homes for appointments. If this rule is finalized as proposed, it may be a helpful template for SBEs.

Agents and Brokers. The Proposed 2024 NBPP would expand consumer protection by requiring agents and brokers, i.e., producers, to obtain certification from consumers that information on an application has been reviewed and is accurate. The Proposed 2024 NBPP would also require producers to receive consent from the consumer in order to make any changes on their application. Both proposed changes would provide another level of security for the consumer in the application process. These proposed changes are applicable to FFEs and SBE-FPs, but may serve as helpful templates for SBEs.

Standardized Plans. The Department notes the proposal to revise 45 C.F.R. § 156.201 to require standardized plans for FFM and SBE-FP states. The Department recognizes that for consumers, the health insurance market can be difficult to navigate if there are a significant number of plans offered. The Department is supportive of limiting the number of non-standardized plans per product network and metal level. This is an important proposal that could help consumers make better, more informed decisions about what plan they are choosing and, in turn, the coverage they will receive. Having this requirement in regulation will serve as a helpful template for consideration by SBE states.

Network Adequacy: Wait Times. While the proposed rule would require all QHPs to comply with network adequacy standards, the proposed rule would not extend appointment wait time criteria to SBEs. Nevertheless, the Department is of the view that wait times are an important metric to include when looking at network adequacy, particularly as telemedicine becomes more integrated into the warp and woof of the health care coverage and delivery system. The Department suggests that a minimum floor applicable to all exchanges, including SBEs, would be a praiseworthy consumer protection.

The proposed regulations commented on above, if implemented, would be an important step forward in assuring that consumers have adequate provider networks and the ability to make better decisions about their health care plans, and in continuing to focus on making behavioral health coverage increasingly robust. The Department appreciates CMS's proposals in this Proposed 2024 NBPP.

Sincerely,



Michael Humphreys

Acting Commissioner

Pennsylvania Insurance Department

SPAN Parent Advocacy Network & Family Voices-New Jersey comments on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

January 30, 2023

Thank you for the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2024. The SPAN Parent Advocacy Network (SPAN) is NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and RSA Transition Parent Information and Training Center. We are the NJ State Affiliate Organization (SAO) of Family Voices, the NJ State Organization of the Federation of Families for Children's Mental Health, and the NJ affiliate of Parent-to-Parent USA. We also house a Military Family 360 Support program. Our comments today are based on our 35 years of work supporting diverse families in advocacy on behalf of their children as well as in systems improvement activities across healthcare.

SUMMARY:

We acknowledge that this proposal addresses payment parameters, updating standardized plan options, and special enrollment periods (SEPs).

B. Summary of Major Provisions

1. 45 CFR Part 153

We understand that the intent is to “recalibrate the 2024 benefit year risk adjustment models... We propose to use only 2018 and 2019 benefit year enrollee level EDGE data in the recalibration of the adult age-sex coefficients to account for the observed anomalies in the 2020”. We **agree** with this in theory but **do not support** utilizing age-sex coefficients which will result in health disparities.

2. 45 CFR Part 155

We understand this affects “approval timelines for States transitioning from either a FFE to a SBE–FP or to a State-based Exchange (SBE), or from a SBE–FP to a SBE”. We **strongly support** this flexibility as long as “such approval is provided at some point prior to” implementation.

We **support** that “agents, brokers, or web-brokers assisting consumers with completing eligibility” must verify “application information has been reviewed by and confirmed to be accurate by the consumer”. Further, the agents must produce “a record of consent”. We **support** that brokers “would be required to maintain the consent documentation for a minimum of 10 years”.

We **strongly support** acceptance of and “applicant’s attestation of projected annual household”.

We acknowledge that there are “changes to the re-enrollment hierarchy” but have some concerns which are noted in the sections below.

We **strongly disagree** with the proposal to “allow Exchanges to direct reenrollment for CSR-eligible enrollees from a bronze QHP to a silver QHP with a lower or equivalent net premium” regardless as to “whether the enrollee’s current plan is available” as this negates consumer choice, consumers should know if they can stay in their current plan, and the switch may cause a change in the provider network adversely affecting continuity of care.

We **support** the new requirement that “only one person in a tax household applying for coverage or financial assistance through the Exchange must qualify for an SEP” to make determinations for the entire household, which will streamline the process.

We **strongly support** the proposal to “permit Exchanges to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC” as this will provide continuous access to care.

We also **support** the proposal to “implement a new special rule for consumers eligible for a SEP under § 155.420(d)(1) due to loss of Medicaid or CHIP coverage”.

3. 45 CFR Part 156

We **agree** that this will allow “appellants and other parties with accurate information about the availability of administrative review by the CMS Administrator if they are dissatisfied with their eligibility appeal”.

III. Provisions of the Proposed Regulations

A. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

We acknowledge that there will be a “FFE user fee rate of 2.5 percent of total monthly premiums and an SBE–FP user fee rate of 2.0 percent of total monthly premiums”.

We **oppose** the proposal to “no longer include a standardized plan option for the non-expanded bronze metal level” as benefits will be inconsistent.

We understand but **disagree** that to “mitigate the risk of choice overload, HHS proposes to limit the number of non-standardized plan options that QHP issuers may offer” again due to inconsistencies in benefits available to consumers.

We acknowledge the proposal for a “stand-alone dental plan (SADP) issuers to use age” and **support** the proposal to “reduce the risk of incorrect APTC calculation for the pediatric dental”.

We **strongly support** the requirement for plans to “include correct information, without omission of material fact, and not include content that is misleading”.

We also **strongly agree** that “individual market QHPs and SADPs and all Small Business Health Options Program (SHOP) QHPs across all Exchanges must use a network of providers that complies with the network adequacy”.

We **support** the establishment of “two additional stand-alone ECP categories at § 156.235(a)(2)(ii)(B) for PY 2024 and subsequent PYs, Mental Health Facilities and Substance Use Disorder Treatment Centers. HHS also proposes to require QHP issuers to contract with at least 35 percent of available FQHCs...” as mental health is an area of need and FQHCs increase healthcare access to underserved families.

We **support** the proposal “to add a timeliness standard to the requirement at § 156.270(f) for QHP issuers to send enrollees a notice of payment delinquency”. We also **support** the requirement for issuers to “describe all inaccuracies identified in a payment and collections”.

1. Sequestration

We acknowledge the “risk adjustment program will be sequestered at a rate of 5.7 percent for payments made from fiscal year 2023”.

2. HHS Risk Adjustment (§ 153.320)

We **strongly disagree** that for the enrollee it should be “based on that person’s age, sex, and diagnoses” as this discriminatory practice negates pre-existing condition exclusion protections and increases health disparities.

a. Data for Risk Adjustment Model Recalibration for 2024 Benefit Year

We agree with the proposal “to use 2018, 2019 and 2020 benefit year enrollee-level EDGE data to recalibrate the 2024 benefit year risk adjustment models with an exception to exclude the 2020 benefit” due to the pandemic.

We appreciated the consideration of options to recalculate 2018-20 enrollee-level EDGE data, lower the weight of 2020 data, use 2017-20 data, exclude 2020 benefit year in adult models, exclude 2020 EDGE data, or use 2018-19 data only; we **agree** with excluding or minimizing the impact of 2020 data due to the pandemic.

Table 1

We are concerned with the discussion of “gender dysphoria” as the DSM-V states that it is not a mental illness, but rather incongruity between one’s experienced gender vs. assigned gender. The discussion is stigmatizing and using an outdated medical model and we **support** use of ICD-10 diagnosis codes as they are updated to reflect “changing clinical concepts and labels”.

Table 2 – no additional comments.

Table 3

Cancer should not just look at patient factors but systemic plan factors such as delays in

preauthorization. A recent study showed that prior authorization caused 96% delays in treatments, 88% in increased costs, and an astonishing 36% of deaths (see [Prior authorization leads to ‘indefensible delays’ in cancer care](#)).

Table 4

We note the concerns with septicemia and sepsis however again data needs to go beyond that to address hospital acquired infections.

We have no additional comments for Tables 5-8.

f. Model Performance Statistics

Table 9 –no additional comments.

3. Overview of the HHS Risk Adjustment Methodology (§ 153.320) – no comments.

4. Repeal of Risk Adjustment State Flexibility To Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))

Although we understand that this is “including those prior participant States that previously requested a reduction” we are **concerned** about possible unintended consequences.

a. Repeal of State Flexibility To Request Transfer Reductions

Again, we acknowledge that this will allow a “State to request a reduction in risk adjustment State transfers beginning with the 2025” but are **concerned** about implications.

b. Requests To Reduce Risk Adjustment Transfers for the 2024 Benefit Year – no comments.

5. Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, and 153.710)

We acknowledge the proposal is to “collect and extract from issuers’ EDGE servers through issuers’ EDGE Server Enrollment Submission (ESES) files and risk adjustment recalibration”.

a. Collection and Extraction of the QSEHRA Indicator

We are **concerned** about the fact that the “indicator available in the enrollee-level EDGE” as it relates to HIPAA.

b. Extracting Plan ID and Rating Area

Here again we are **concerned** about “enrollee-level EDGE data” due to HIPAA.

Although we examining historical trends, we would suggest identification of systemic issues for accountability/enforcement.

6. Risk Adjustment User Fee for 2024 Benefit Year (§ 153.610(f)) – no comments.

7. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS–RADV) (§§ 153.350 and 153.630)

We **support** the proposal in “providing accurate high-quality information to HHS”.

a. Materiality Threshold for Risk Adjustment Data Validation

We **disagree** with the proposal that those that “fall below the new proposed materiality threshold would not be subject to the annual IVA (and SVA) audit requirements, but may be selected to participate in a given benefit year of HHS–RADV based on random sampling” as this reduces accountability and transparency.

b. HHS–RADV Adjustments for Issuers That Have Exited the Market

We **agree** that it “is no longer necessary to treat exiting issuers differently from non-exiting issuers when they are negative error rate outliers”.

c. Discontinue Lifelong Permanent Conditions List and Use of Non-EDGE Claims in HHS–RADV

We **agree** with “discontinuing the use of the Lifelong Permanent Conditions (LLPC) list” but are **concerned** that it “was designed to ease the burden of medical record retrieval” in which administrative convenience overrides the right to health care privacy. Although we understand that there was a concern for issuer incentives to include LLPC diagnoses even if untreated which certainly occurs in medically complex consumers, we note that there is a wide range of outcomes even within the same diagnosis.

d. HHS–RADV Discrepancy and Administrative Appeals Process

We **support** the proposal to “shorten the window to confirm the findings of the SVA (if applicable) or file a discrepancy... to within 15 calendar days”.

8. EDGE Discrepancy Materiality Threshold (§ 153.710) – no comments.

B. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Exchange Blueprint Approval Timelines (§ 155.106)

As stated above, we **support** the “proposal to require Exchange Blueprint approval or conditional approval prior to an Exchange’s first open enrollment period would allow States the additional time and flexibility”.

2. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

a. Repeal of Prohibitions on Door-to-Door and Other Direct Contacts

We **support** this proposal which will maximize “pathways to enrollment”.

3. Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals,

Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220) where there are sufficiently severe findings of non-compliance

a. Extension of Time To Review Suspension Rebuttal Evidence and Termination Reconsideration Requests (§ 155.220(g) and (h))

We **support** the “additional 15 or 30 calendar days to review evidence submitted by agents, brokers, or web-brokers to rebut allegations that led to suspension of their Exchange agreement”.

b. Providing Correct Information to the FFEs (§ 155.220(j))

As stated previously, we **support** the requirement that that information has “been reviewed by and confirmed to be accurate by the consumer”.

c. Documenting Receipt of Consumer Consent (§ 155.220(j))

As stated above, we **agree** with the need to “document the receipt of consent from the consumer”.

4. Eligibility Standards (§ 155.305)

a. Failure to File and Reconcile Process (§ 155.305(f)(4))

We **agree** with the additional flexibility regarding eligibility to eliminate the obstacle if the consumer “failed to file a Federal income tax return”.

5. Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320) Income Inconsistencies

As stated previously, we **strongly support** the proposal to “accept an applicant’s or enrollee’s attestation”.

6. Annual Eligibility Redetermination (§ 155.335)

Here again we **strongly disagree** with the proposal to “be automatically reenrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium” as consumers may wish to retain their plan and providers.

7. Special Enrollment Periods (§ 155.420)

a. Use of Special Enrollment Periods by Enrollees

As stated above we **strongly agree** with the need that “only one person in a tax household applying for coverage or financial assistance” to streamline household eligibility.

b. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

As stated previously we **strongly support** the provision to “offer earlier coverage effective start dates for consumers attesting to a future loss of MEC”.

c. Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

We are concerned that only “three percent of beneficiaries who were disenrolled from Medicaid or CHIP in 2018 enrolled in Exchange coverage within 12 months” which indicates the need for referral to alternatives.

d. Plan Display Error Special Enrollment Periods (§ 155.420(d))

We **support** an SEP for a consumer “adversely affected by a plan display error”.

8. Termination of Exchange Enrollment or Coverage (§ 155.430)

a. Prohibition of Mid-Plan Year Coverage Termination for Dependent Children Who Reach the Maximum Age

We **strongly support** the prohibition “from terminating coverage of dependent children”. However, consumers must also be informed that some states have higher dependent coverage ages (in NJ it is 30) and that individuals with developmental disabilities are covered regardless of age due to the federal disabled dependent provision.

9. General Eligibility Appeals Requirements (§ 155.505)

We **support** and “acknowledge the ability of the CMS Administrator to review Exchange eligibility appeals decisions prior to judicial review”.

10. Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges (§§ 155.1500 Through 155.1515)

We **support** that this “will include State Exchanges”.

Purpose and Scope (§ 155.1500) measurement of improper pay – no comments

Definitions (§ 155.1505) – no comments

Data Submission (§ 155.1510)

We **agree** with the use of a “form to collect and compile information from each State Exchange”.

d. Pre-Testing and Assessment Procedures (§ 155.1515)

We **agree** with the need to “prepare State Exchanges for the planned measurement of improper payments”.

C. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. FFE and SBE–FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

a. FFE User Fee Rates for the 2024 Benefit Year

b. SBE–FP User Fee Rates for the 2024 Benefit Year

2. Publication of the 2024 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage

in Guidance (§ 156.130)

We have no addition comments on items 1 and 2.

3. Standardized Plan Options (§ 156.201)

As stated above, we **disagree** with the proposal to “no longer include a standardized plan option for the non-expanded bronze metal level”. We also **disagree** with the need for a “standardized plan options for the following metal levels” as this will adversely affect available benefits.

As stated previously we **opposed** the proposal “to discontinue standardized plan options for the non-expanded bronze metal level mainly due to AV constraints”. We seek clarification on the statement that “it is not feasible to design a non-expanded bronze plan that includes any pre deductible coverage while maintaining an AV within the permissible AV de minimis range for the non-expanded bronze metal level”.

We have no additional comments on Tables 10-11.

4. Non-Standardized Plan Option Limits (§ 156.202) – no comments.

5. QHP Rate and Benefit Information (§ 156.210) Age on Effective Date for SADPs stand-alone dental plans (SADPs), as a condition of Exchange certification, to use an enrollee’s age

As stated above, we **agree** to “require issuers of SADPs, as a condition of Exchange certification, to submit guaranteed rate”.

6. Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

As previously stated we **agree** that plans must “include correct information, without omission of material fact, and do not include content that is misleading”.

7. Plans That Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

As stated above we **agree** to “remove the exception that these sections do not apply to plans that do not use a provider network”.

Table 12 – no comments

8. Essential Community Providers (§ 156.235)

Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers.

As stated previously, we **agree** with the requirements around mental health and FQHCs.

Table 13

9. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

a. Establishing a Timeliness Standard for Notices of Payment Delinquency

As stated before we **agree** with the new “timeliness standard to the requirement for QHP issuers to send enrollees notice of payment”.

10. Final Deadline for Reporting Enrollment and Payment Inaccuracies Discovered After the Initial 90-Day Reporting Window (§ 156.1210(c))

As stated previously we **support** the requirement to “describe all data inaccuracies identified in a payment and collection”.

11. Administrative Appeals (§ 156.1220)

Again, we **agree** with the “new proposed 15-calendar-day window to confirm, or file a discrepancy, for SVA”.

Thank you again for the opportunity to provide input on the proposed payment parameters.

Sincerely,

Carolyn Hayer

Carolyn Hayer
Executive Co-Director, SPAN
35 Halsey St., 4th Fl.
Newark, NJ 07102
chayer@spanadvocacy.org
spanadvocacy.org

Lauren Agoratus

Lauren Agoratus, M.A.-parent
NJ Coordinator- Family Voices @ SPAN
35 Halsey St., 4th Fl.
Newark, NJ 07102
familyvoices@spanadvocacy.org
spanadvocacy.org

To empower families and inform and involve professionals and other individuals interested in the healthy development and education of children, to enable all children to become fully participating and contributing members of our communities and society.



January 27, 2023,

Submitted via www.regulations.gov¹

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-9899-P (RIN 0938-AU97)

Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: DOCKET ID CMS-9899-P, RIN 0938-AU97, 87 FR 78206, Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

Equitas Health is a federally designated community health center and one of the largest LGBTQ+ and HIV/AIDS serving healthcare organizations in the country. Each year, we serve tens of thousands of patients in Ohio, Texas, Kentucky, and West Virginia, and since 1984, we have been working to advance “care for all.” Our mission is to be the gateway to good health for those at risk of or affected by HIV; for the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community; and for those seeking a welcoming healthcare home. In doing so, we offer primary and specialized medical care, pharmacy services, dentistry, mental health and recovery services, HIV/STI prevention and treatment services, Ryan White HIV case management, overall care navigation, and a number of community health initiatives. The implementation of this important rule is crucial both to our agency and our patients, because it better ensures access to care for medically underserved communities.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, Equitas Health, as with many other FQHCs across the country, assisted individuals who were seeking coverage in 2021. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. Equitas Health greatly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration’s proposed changes in the proposed rule “Streamlining the Medicaid, Children’s Health

¹ Document prepared by Rhea Debussy, Ph.D. (she/her), Director of External Affairs with assistance from the National Association of Community Health Centers (NACHC); document reviewed by Sam Brinker (he/him), General Counsel and Sarah Green (they/she), Administrative Assistant

Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

Equitas Health also welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

Equitas Health supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)² to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. Equitas Health recommends that CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, Equitas Health recommends that CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As OUR ORGANIZATION has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. Equitas Health recommends that CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”³ but given the crucial role health centers play in delivering primary care services, Equitas Health believes that these good-faith contracts should extend to all FQHCs in their service area.

Equitas Health recommends that CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate⁴ unless they have agreed on an in-network, contracted

² Section 1311(c)(1)(C)

³ <https://www.gbpccertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

⁴ Section 1902(bb) of the Social Security Act

payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like Equitas Health, to engage with states and hold them accountable. Equitas Health recommends that CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁵ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, legal clinics, housing support, and more. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

Equitas Health strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. Equitas Health appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee’s residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to

⁵ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

solicit enrollment assistance. Equitas Health appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

Equitas Health also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁶ With the median U.S. household income reported at \$70,784 in 2021,⁷ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

Equitas Health also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁸ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Increasing Health Insurance Enrollee Protections

Equitas Health supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,⁹ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁰ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person.>

⁷ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1.>

⁸ [https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.](https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/)

⁹ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁰ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

Equitas Health supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹¹ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, Equitas Health applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and Equitas Health also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. Equitas Health appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

Equitas Health also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OUR ORGANIZATION appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

Equitas Health recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection Equitas Health supports the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the

¹¹ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Dr. Rhea Debussy (she/her), Director of External Affairs at Equitas Health.

January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Rule; Patient Protection and Affordable Care Act, HHS Notice of Benefits and Payment Parameters for 2024. Centers for Medicare & Medicaid Services, Department of Health and Human Services (CMS-9899-P)

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the Notice of Proposed Rulemaking on the Notice of Benefits and Payment Parameters (NBPP) for 2024 published in the *Federal Register* on December 21, 2022. The AMA appreciates that the proposed rule would continue CMS recent efforts to simplify consumer choice and improve the plan selection process in the Affordable Care Act (ACA) marketplaces; increase network adequacy requirements and essential community providers (ECP) categories; expand provisions for navigators and other consumer assisters; and establish new rules for agents, brokers, and web-brokers that assist consumers with enrollments. Our comments focus on these provisions. The AMA commends the Administration for its commitment to extending health insurance coverage to more Americans and making it easier and more affordable to get covered.

Standardized Plan Options

CMS continues its approach from the 2023 NBPP to simplify consumer choice and improve the plan selection process in the ACA marketplaces. In last year's NBPP, CMS re-introduced standardized plans (named "Easy Pricing" plans), pursuant to which issuers that offer qualified health plans (QHPs) through the federal marketplaces to offer standardized benefit plans designed by CMS for every product network type, at every metal level, and throughout every service area in which they offer non-standardized plans. Consumers can apply filters on HealthCare.gov to view and compare only standardized plans. The AMA supported these changes.

For Plan Year (PY) 2024, CMS proposes to continue the Easy Pricing plans with a few minor changes. First, issuers would no longer be required to offer a standardized plan at the non-expanded bronze metal level ("expanded" Bronze plans cover at least one non-preventive service pre-deductible or meet the IRS' definition of a high-deductible health plan and are permitted to have an actuarial value of up to 5 points above the 60 percent standard). CMS' rationale for this change is mainly due to actuarial value (AV) constraints; the agency explains that it was not feasible to design a non-expanded bronze plan that

includes any pre-deductible coverage that meets the AV target within the allowable de minimis range. CMS also noted that most issuers in the federal marketplace chose not to offer non-expanded bronze plans. We agree with the agency that this proposed change would minimize burden without any negative consequences, particularly since CMS clarifies that issuers would still be allowed to offer non-standardized plan options at the non-expanded bronze level, thereby giving consumers the ability to choose those plan options.

CMS also intends to continue the use of four prescription drug tiers in its standardized plans, i.e., generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. We agree with the agency that limiting the formulary to these four tiers helps to promote understandable drug coverage and facilitates consumers' ability to compare plan options, but we remain concerned about continuing reports that some issuers are not placing certain drugs at the appropriate cost-sharing tiers. We also remain concerned by long-standing research showing adverse and discriminatory tiering policies from payers that result in patient harm. That is why we support the proposal to require issuers to place all covered drugs in the appropriate cost-sharing tier unless there is an appropriate and non-discriminatory, i.e., clinical, basis for placing the drug in the specialty tier. We also urge CMS to monitor issuers' tiering strategies to ensure that payers comply with this new requirement, especially those issuers that have been the subject of complaints.

Further, the 2024 NBPP proposes to limit the number of non-standardized plans that issuers may offer in the marketplaces to two per product network type and metal level, per service area. This change is based on what CMS sees as a continuing need to reduce the overwhelming number of options consumers face on the marketplaces and would reduce the average number of non-standardized plans available to about three dozen, down from over 100. As an alternative approach to limiting the number of issuers' plan offerings, CMS is proposing to reinstate a "meaningful difference" standard, basically a modified version of what the Obama Administration had introduced in 2015. CMS proposes to group plans by county, issuer ID, metal level, product network type, and deductible integration type, and then evaluate whether plans within each group are "meaningful different" than other plans offered by the issuer, based on differences in deductible amounts, which would have to differ by more than \$1000.

The AMA supports the latter alternative. The intent of health insurance exchanges is to provide a patient-friendly market for patients to purchase health insurance, as well as increase the competition among plans based on quality and price. In general, patients must navigate through many health plans to make the right choice that responds to their health care needs and budgetary realities. An issue brief released by the Office of Health Policy of the Assistant Secretary for Planning and Evaluation (ASPE) in December 2021 showed that nearly three-quarters of HealthCare.gov consumers have more than 60 plan options to choose from, and more than a quarter must select from more than 160 different plans. Within a specific metal tier, or even within a particular metal tier and a specific issuer, patients still can still face a high number of health plan options from which to choose. Approximately half of HealthCare.gov consumers have more than 40 plan options in the silver tier from which to choose, with nearly three-quarters having more than ten silver plans available from at least one issuer in their county. The AMA agrees that navigating this wide range of health plan choices available on health insurance exchanges may be potentially difficult and confusing for patients, and therefore we support efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

Annual Eligibility Redetermination (Re-enrollment Hierarchy)

Under the proposed rule, marketplaces would be allowed to modify their automatic enrollment hierarchies for assigning enrollees to plans who do not actively reenroll. Enrollees eligible for cost-sharing reduction

would be assigned to silver plans that have cost-sharing reductions available, if their premiums are not increased, rather than being reenrolled in bronze plans for which reduced cost-sharing reductions are not available. In addition, enrollees who are reassigned and enrollees whose previous plans are no longer available would be reassigned to the plan with the most similar network to their prior plan. The AMA supports these changes.

Network Adequacy and Essential Community Providers

Wait Times

The AMA strongly supports CMS' inclusion of wait time requirements into the measurement of network adequacy. We view this standard, combined with other quantitative standards, as critical to determining if a network can serve the needs of enrollees. Often a network provider may be conveniently located but not be accepting new patients or have appointments available in the timeframe needed given their patient load, and wait time requirements could help a plan and regulator address such access issues. As such, we urge CMS to move forward with implementation of this requirement as quickly as possible. We also urge CMS to consider additional tools to measure compliance beyond insurer attestation, including audits, secret shopper programs, and patient interviews/surveys.

Additionally, as the AMA continues to hear from physicians who are being terminated without cause from health insurance networks, we urge CMS to ensure that plans are not making material changes to their networks during the plan year to promote and ensure continuity of care for patients. This would include changes that terminate physicians from the plan's network or contract changes that make it unattractive or unsustainable for a physician to remain in network. CMS should also monitor network plans throughout the year for their continued adequacy while requiring plans to immediately report changes to the network that may impact access to care for patients.

Essential Community Providers

The AMA strongly supports the 2024 proposed addition of two new essential community provider (ECP) categories, Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers. If finalized as proposed, substance use disorder treatment centers and mental health facilities that would be available on the ECP List would be limited to those facilities identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and/or CMS as providing such services, in addition to fulfilling other ECP qualification requirements. ECPs include those that care for individuals in low-income and/or medically underserved communities and it is important that all communities have affordable, convenient and timely access to evidence-based mental health facilities and SUD treatment centers.

In addition to this ECP proposal, the AMA urges CMS to consider additional ways to expand access to mental health and SUD services in underserved communities, including through network adequacy requirements and mental health and SUD parity enforcement.

Additionally, the AMA supports proposed changes to extend the 35 percent threshold to Federally Qualified Health Centers (FQHCs) and family planning providers. These changes would increase provider choice and access to care for low-income and medically underserved consumers, and with regard to family planning providers, are particularly important in states that have banned abortion services.

Requirements for Qualified Health Plan and Plan (QHP) Variant Marketing Names

CMS proposes to require that QHP and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. This proposal is in response to consumer complaints from numerous states about misleading or deceptive plan marketing names. According to CMS, in PY 2022, there was a significant increase in the number of plan and plan variation marketing names using cost-sharing information and other benefit details on the federal marketplace, which resulted in consumer confusion. The AMA supports this proposed change and agrees with CMS that providing standards to help ensure plan marketing names are clear and accurate will reduce burden and confusion for consumers and on navigators and other assisters who help consumers enroll in marketplace coverage. We also agree with the agency that these changes would promote health equity by reducing the likelihood that consumers might misunderstand or be confused about QHP benefits, especially for those consumers with low health literacy, which is disproportionately experienced among underserved and vulnerable populations.

Special Enrollment Periods

CMS proposes giving marketplaces the option to implement a new rule which would allow consumers up to 90 days after their loss of Medicaid or CHIP coverage to select a marketplace plan. Currently, individuals who lose minimum essential coverage have up to 60 days before and up to 60 days after their coverage loss to select a marketplace plan. CMS also proposes to change current coverage effective date requirements so that marketplaces have the option to offer earlier effective start dates for consumers attesting to a future loss of coverage. The AMA supports these changes and urges CMS to retain them in the final rule.

The proposed Special Enrollment period (SEP) changes intend to mitigate coverage gaps for individuals who lose Medicaid or CHIP coverage and are eligible to enroll in marketplace plans. Even brief gaps in coverage can be disruptive in terms of interrupting necessary services and treatments, medication adherence, continuity of care, and in some cases, higher health care costs when delayed care results in more expensive health care needs. Accordingly, the AMA supports efforts to ensure that individuals determined ineligible for Medicaid or CHIP are seamlessly transitioned to other affordable coverage for which they are eligible. Once the continuous enrollment requirement ends on March 31, 2023, smooth transitions between Medicaid and marketplace plans will be even more critical as potentially millions of individuals are determined ineligible for Medicaid. The proposed SEP changes may reduce—but not eliminate—gaps in coverage for significant numbers of individuals disenrolled from Medicaid who qualify for marketplace plans. To further streamline coverage transitions in the future, the AMA supports automatic coverage transitions that meet certain standards around consent and an ability to opt out and that include targeted outreach and streamlined enrollment mechanisms, which include raising awareness of the availability of premium tax credits and cost-sharing reductions, as well as special enrollment periods.

Standards for Navigators and other Consumer Assisters

CMS proposes to allow navigators and other similar consumer assisters to conduct door-to-door enrollment to consumers. Assisters are currently allowed to do door-to-door outreach, education, and schedule follow-up appointments, but are banned from providing enrollment assistance during the initial contact at the consumers' residence. CMS is now proposing to lift this prohibition. Since the agency has already established safeguards to ensure that navigators and assisters maintain the privacy and security of consumers' information, the AMA supports this proposal. We agree with CMS that making this change

will help lift barriers for consumers who must make follow-up appointments for enrollment assistance and for those individuals who may have mobility issues, may not be able to afford to travel for assistance, or who are immunocompromised.

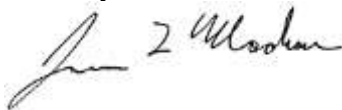
CMS is also proposing new requirements related to agents, brokers, or web-brokers, who would be required to obtain recorded oral or written consent from all individuals they enroll in coverage, as well as document that an applicant reviewed and confirmed the accuracy of eligibility application information has been reviewed and confirmed to be accurate by the consumer prior to application submission. The AMA supports these proposals, which would reduce the possibility that people will be enrolled without their consent.

Co-Pay Accumulator Programs

To offer additional protections for patients with chronic conditions, the AMA urges CMS to prohibit insurers' discriminatory co-pay accumulator policies in the final regulation. Co-pay accumulator programs target individuals in need of specialty drugs (often individuals with chronic and/or complex conditions) who need assistance to meet their financial obligations under their health plan. Co-pay assistance often is the only way that patients with chronic conditions can afford their medication and co-pay accumulator programs prevent patient access by denying them any financial relief from insurmountable cost sharing obligations. These policies also reduce the value of premiums paid by patients with chronic conditions by allowing health plans to "double dip" and accept both the co-pay assistance obtained by the patient and the additional cost-sharing then paid by the patient before the patient reaches their out-of-pocket limits. This exposes these patients to ongoing charges for their prescription drugs as well as any other health care coverage they (or their families) may need during the year. As such, we urge CMS to prohibit co-pay accumulator programs in the final rule.

Thank you for considering the AMA's comments. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jim L. Madara", written in a cursive style.

James L. Madara, MD



AWHIB

The Association of Web-Based Health Insurance Brokers

January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 —AWHIB Comments

Dear Administrator Brooks-LaSure:

On behalf of the Association of Web-Based Health Insurance Brokers (AWHIB) and its member companies, we appreciate the opportunity to comment on CMS-9899-P, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters Proposed Rule. AWHIB is a trade association of web-broker entities (WBEs) that are currently leveraging the Federally-facilitated Exchange's (FFE) Direct Enrollment and Enhanced Direct Enrollment application programming interfaces (APIs). AWHIB collaborates with consumers, issuers, regulators, lawmakers, and other industry groups to continually develop technologies and enrollment strategies that provide Americans with access to health insurance products and services.

Based on a review of the proposed rule, AWHIB requests the Department consider the following recommendations and perspectives as it finalizes the proposed rule.

Providing Correct Information to the FFEs (45 CFR §155.220(j))

AWHIB recommends that the proposed standard not apply when consumers are completing the application themselves when using a web-broker's website. CMS proposes to revise §155.220(j) to require agents/brokers and web-brokers assisting individuals applying for APTC and CSRs to document that the eligibility application information has been reviewed and confirmed by the consumer or their authorized representative prior to application submission. The documentation would require the consumer to take an action, such as provide a signature or recorded verbal confirmation. The documentation would need to include the date of review, the name of consumer or authorized representative, explanation of the "penalty of perjury"

attestations at the end of the application, and name of the agent/broker or web-broker. The documentation would need to be maintained for 10 years.

AWHIB understands CMS' concerns about ensuring the accuracy of information on eligibility applications, particularly if the application is not completed by the consumer but instead by an agent or broker on the consumer's behalf. However, AWHIB members recommend that the proposed standard not apply when the consumer is completing an application on a web-broker's website in self-service mode. AWHIB members do not believe that the documentation is necessary when consumers are completing the application on their own without the assistance of an agent or broker and is concerned that the documentation would add unnecessary friction and reduce enrollment conversion rates. This would also create an imbalance with the user experience on Healthcare.gov, where consumers would presumably not be required to complete the additional documentation step.

While AWHIB recognizes CMS' concern about the accuracy of applications, AWHIB recommends that CMS share complaint rate data regarding application accuracy for applications completed by agents/brokers and web-brokers versus other Marketplace channels, such as the Marketplace Call Center, Healthcare.gov and navigators and assisters to help determine whether the proposed standard is needed.

Should CMS codify the proposed standard, AWHIB concurs with not specifying the specific method in regulation and providing agents/brokers and web-brokers with flexibility on how best to collect, record and store the documentation, as well as where confirmation should be collected from the consumer. This would help web-brokers to determine how best to incorporate the confirmation and documentation process efficiently within the application and enrollment experience. AWHIB also concurs that an application filer should be able to review and confirm application accuracy on behalf of other applicants on the same application. This would be consistent with the rest of the application process and would be far more workable than requiring each applicant to review and confirm application accuracy.

Documenting Receipt of Consumer Consent (45 CFR §155.220(j))

AWHIB recommends providing flexibility on how to collect, document, revoke and store consumer consent. CMS proposes to revise 45 CFR §155.220(j)(2)(iii) to require agents/brokers and web-brokers assisting with enrollment through FFEs or SBE-FPs or assisting an individual in applying for APTCs and CSRs to document the receipt of consumer consent. The consent provision would require the consumer to take an action, such as provide a signature or recorded verbal confirmation. The agent/broker or web-broker would need to document the date of consent; name of consumer or authorized representative; name of agent, broker or web-broker to which consent is granted; include the scope, purpose and duration of consent; and include the process for rescinding consent. The consent documentation would need to be maintained for 10 years.

AWHIB recognizes the importance of obtaining consent from consumers when assisting consumers in completing their application and enrollment. While we want to make sure that the process of providing consent is clear to the consumer, it should also be workable and efficient with minimal unnecessary friction.

Should CMS codify the proposed standard, AWHIB recommends that CMS provide discretion to web-brokers on not only the method for collecting consent, but also where consent can be collected as well as the scope, purpose and duration of the consent. The method of how and where consumer consent is best provided as well as the scope, purpose and duration of consent may vary based upon the business model of the web-broker. For example, the method and location for collecting consent may differ based upon whether the consumer is working with a web-broker in self-service mode, or whether they are working with an agent using the web-broker's platform. Furthermore, the scope, purpose and duration may differ depending upon whether the consumer is working with a web-broker that only supports enrollment in Marketplace coverage vs a web-broker that offers a range of insurance products in addition to Marketplace coverage (e.g., dental, vision, other ancillary coverage).

AWHIB also recommends that consumers be able to grant consent to multiple agents/brokers and web-brokers simultaneously, and that consent be considered terminated only if limited by a specific duration or if specifically rescinded. Attempting to limit consent to a single agent, broker or web-broker at any given time could be difficult to manage. Establishing and recording consent, even with multiple entities at the same time, would establish a record of the entities with whom the consumer intended to work on his/her behalf.

Limits on Non-Standardized Plan Options (45 CFR §156.202)

AWHIB recommends not finalizing the proposal to limit the number of non-standardized plan options to two per product network type and metal level. CMS proposes to amend 45 CFR §156.202 to limit the number of non-standardized plans a QHP issuer can offer to two non-standardized plan options per product network type and metal level in a given service area. AWHIB recognizes CMS' concerns about consumers having to sift through a high volume of plans with minimal benefit and/or network differences. However, AWHIB is also concerned that imposing a limit of two plan options per product network type and metal level is arbitrary and could constrain issuers' ability to offer innovative plan designs. AWHIB instead proposes that CMS consider reinstituting previously codified meaningful difference standards to strengthen distinctions between non-standard plan options while preserving issuer ability to offer innovative plan designs. Under the previous standard, a plan was considered "meaningfully different" from another plan offered by the same issuer if consumer could reasonably identify material differences between plan characteristics such as cost sharing or out-of-pocket maximum; provider network; covered benefits; plan type; HSA eligibility; or self-only, non-self-only, or child only offerings. Furthermore, web-broker decision support tools can help consumers and their agents sort through the available options (both standardized and non-standardized) and identify a plan or set plan options that best meet the consumer's needs.

Closing

AWHIB appreciates the opportunity to offer comments on the proposed rule. We look forward to continuing to partner with CMS and states to enroll consumers in health insurance coverage across the nation.

Sincerely,

The Association of Web-Based Health Insurance Brokers



January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

I am writing on behalf of Colorado Community Health Network (CCHN) in response to HHS's Notice of Benefit and Payment Parameters for 2024 (CMS-9899-P). CCHN is the membership organization for Colorado's 20 Federally Qualified Health Centers (FQHCs) which operate over 240 clinic sites across the state and act as the health care home to more than 855,000 Coloradans from 63 of the state's 64 counties. FQHCs serve people regardless of their insurance status or ability to pay; over 52% of patients are covered by the state's Medicaid program.

CCHN welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; III. Cuts to User Fees; and IV. Increasing Health Insurance Enrollee Protections.

CCHN strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

I. Enhancing Network Adequacy Through Essential Community Providers

CCHN supports CMS' proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%.

FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. CCHN recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

¹ Section 1311(c)(1)(C)

Additionally, to ensure that insurers are contracting with FQHCs, CCHN recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role FQHCs play in delivering primary care services, CCHN believes that these good-faith contracts should extend to all FQHCs in their service area.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”³ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. FQHCs use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. FQHCs greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

CCHN strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. FQHCs leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. FQHCs employ dedicated staff, such as health navigators, community health workers, and assistants, who help consumers understand and enroll in health insurance coverage options. Navigators being able to travel to an enrollee’s residence enhances the opportunity to get more people enrolled in health insurance coverage, particularly as health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. CCHN appreciates the additional flexibility to go into the community and reach the patients who need the most support.

CCHN also appreciates CMS’ proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

their loss of insurance, to select a plan under the Exchange. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for FQHC patients.

CCHN also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

III. Cuts to User Fees

CCHN appreciates the Administration's continued investment in the outreach and enrollment workforce. Funding for this workforce is so important for FQHCs and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that FQHCs can reach more patients. This funding has also provided FQHCs the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Colorado expects that at least 315,000 current Medicaid members will lose coverage in the upcoming year, with estimates of 5 to 14 million people nationwide.⁴ Many of these individuals will likely be eligible for coverage on the Marketplace.

CCHN is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports consumer-facing functions that are critical for FQHC across the country because they ultimately impact patient outcomes. More funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage, as we have seen in the past from a decreased in unsubsidized enrollment.⁵ Colorado's State-Based Marketplace, which is funded in part by these user fees, will need the financial support to enrollment, particularly to support new customers through the unwind of the Medicaid Continuous coverage provision.

Rather than cutting the user fee, CCHN recommends they remain at their current percentages: 2.5% in the marketplace and 2.25% in the state-based marketplace. CCHN also advocates strongly for CMS to invest more in outreach and enrollment services in general. Additional federal funding would decrease FQHC and other community provider's reliance on the user fees. In particular, the outreach capabilities would assist health centers in continuing to

⁴ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

⁵ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

employ neutral navigators who provide accurate, unbiased information.⁶ FQHCs will play a crucial role in helping enrollees understand their new coverage as the block on Medicaid disenrollments ends and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

CCHN supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. Requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission will protect consumers' interests as they choose insurance on the Marketplace. While states do report the number of instances in which brokers signed up customers for different coverage than promised or without their consent,⁷ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. Even though many FQHC patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

Similarly, CCHN applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and CCHN also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. FQHCs provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. CCHN appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

CCHN also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. Getting that notice to enrollees expediently, and through different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked. CCHN recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss.

Another enrollee protection CCHN supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies

⁶ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

⁷ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact CCHN's Policy Director, Stephanie Brooks, sbrooks@cchn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "P. Anderson", with a long, sweeping horizontal line extending to the right.

Polly Anderson
Vice President of Strategy and Financing
Colorado Community Health Network

PUBLIC SUBMISSION

As of: 1/31/23, 12:53 PM
Received: January 30, 2023
Status: Posted
Posted: January 31, 2023
Tracking No. 1dj-65yw-ywem
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0144

Comment on CMS-2022-0192-0003

Submitter Information

Name: Derek Ewart

Email: derekewart73@gmail.com

General Comment

I feel that you are already overloading insurance agents with so many regulations that seem unwarranted. The require to create forms to insure ACA enrollees are providing accurate information seems more suited for the Marketplace and IRS, rather than agents, who have to accept what their clients are telling them. Even potentially implementing financial penalties on agents as a result of a client providing inaccurate income information is incredibly heavy handed.

There are also difficulties for self employed, or people who work flexible hours, to accurately estimate a future income. Rather than the ACA using income from previous tax returns to accurately estimate household income, it has everyone having to guess their next year's income. Making agents liable for any inaccuracies is completely insane. At present, any good agent already performs due diligence.

It seems obvious that the person responsible for providing income should be held entirely responsible for ensuring the income is correct, to the best of their knowledge.

Therefore, I ask that this section not be passed or implemented.



January 27, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

The HealthCare Connection, Inc.
1401 Steffen Ave
Cincinnati, Ohio 45215

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. Nine percent of our patients have private insurance and seventy percent of our patients are on Medicaid. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, The HealthCare Connection FQHCs helped nearly 438 individuals seeking coverage in 2021. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. OUR ORGANIZATION strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

The HealthCare Connection welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

The HealthCare Connection supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. The HealthCare Connection recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, THE HEALTHCARE CONNECTION recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As OUR ORGANIZATION has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. **THE HEALTHCARE CONNECTION** recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, **THE HEALTHCARE CONNECTION** believes that these good-faith contracts should extend to all FQHCs in their service area.

¹ Section 1311(c)(1)(C)

² <https://www.ghpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

THE HEALTHCARE CONNECTION recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like **THE HEALTHCARE CONNECTION**, to engage with states and hold them accountable. **THE HEALTHCARE CONNECTION** recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food, health care enrollment and access to community resources. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

THE HEALTHCARE CONNECTION strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. **THE HEALTHCARE CONNECTION** appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. **THE HEALTHCARE CONNECTION** appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

THE HEALTHCARE CONNECTION also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

THE HEALTHCARE CONNECTION also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person.>

⁶ [https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1\).](https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1).)

of insurance or 90 days after their loss of insurance, to select a plan under the Exchange.

Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

THE HEALTHCARE CONNECTION appreciates the Administration’s continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as “billable providers” and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

OUR ORGANIZATION is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Our community health workers improve our patients' quality of life by educating them regarding proper health practices and helping them access community resources. Our enrollment assisters are constantly working with our patients to keep their Medicaid and ACA eligibility active.

Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. The state of Ohio is predicting that 3,000,000 Medicaid recipients will need to go through the redetermination process. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, THE HEALTHCARE CONNECTION supports that they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. THE HEALTHCARE CONNECTION also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

THE HEALTHCARE CONNECTION supports CMS’ proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers’ interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

THE HEALTHCARE CONNECTION supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, THE HEALTHCARE CONNECTION applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and THE HEALTHCARE CONNECTION also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. **THE HEALTHCARE CONNECTION** appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

THE HEALTHCARE CONNECTION also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OUR ORGANIZATION appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

THE HEALTHCARE CONNECTION recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection THE HEALTHCARE CONNECTION supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data

that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact **Charles Woode, Advocacy Coordinator, charlesw3@healthcare-connection.org.**

Sincerely,

Jolene Joseph, CEO



January 30, 2023

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

Re: Comments on *HHS Notice of Benefit and Payment Parameters for 2024* Proposed Rule

Dear Administrator Brooks-LaSure,

The HIV Health Care Access Working Group works to advance policies that ensure the millions of people living with HIV and hepatitis have broad access to comprehensive care and treatment. The Affordable Care Act (ACA) has played a pivotal role in expanding coverage and guaranteeing critical care for people living with serious, chronic conditions, and we appreciate the opportunity to offer comments on Health and Human Services' (HHS) proposed 2024 Notice of Benefit and Payment Parameters (NBPP).

We are pleased to see many provisions in the proposed NBPP continue to expand access to health care, make coverage more affordable, and increase patient protections. We are supportive of the many provisions that support continuity of care as that is essential to people living with HIV and hepatitis. More than half of all new infections of HIV occur among young adults (ages 13-34);¹ ensuring that young adults turning 26 can maintain their current coverage through the end of the plan year will help reduce interruptions to treatment. Additionally, the newly proposed re-enrollment hierarchy for CSR eligible individuals will improve the value and affordability of their coverage which could have positive implications for overall care and health outcomes.

However, we offer our comments below on specific proposals that could impact our focus population, and identify opportunities to further strengthen the rule, ensuring people living with HIV and hepatitis are able to get the care they need.

Protecting Consumers

Central to the (Patient Protection and) Affordable Care Act are consumer protections. The ACA intended to make health insurance coverage not only more affordable and accessible, but also fairer. The law prevents insurers from discriminating based on a pre-existing condition, placing annual or lifetime limits on care, or canceling coverage after a diagnosis. By extension, insurers should not be allowed to utilize misleading marketing tactics. In order for patients with serious chronic conditions, like HIV and hepatitis, to make an informed decision and select coverage that will meet their treatment and health care needs, it is imperative that plans convey accurate information. Plan names that are confusing, or worse, contain

¹ HIV.gov, U.S. Statistics, (October 27, 2022), <https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics>.

misleading information, can be likened to false advertising.² We support CMS' proposal that would require qualified health plan (QHP) marketing names to contain correct information.

Agents, brokers, and web-brokers, like insurers, must be held to the same high standard of consumer protections under the ACA; preventing deceptive, abusive, and fraudulent practices that harm patients and impede their right to health care. Agents, brokers and web-brokers have been known to engage in bad practices, failing to fairly assess consumers for Medicare or Medicaid, steering individuals toward sub-par non-QHPs, and even enrolling consumers into coverage without their consent.³ Consumers seek help from agents and brokers in trust, as knowledgeable sources who can assist with completing and submitting eligibility applications and enrolling in a qualified health plan.⁴ Preying on already vulnerable individuals by intentionally submitting inaccurate information or applying for health insurance without a consumer's consent is unacceptable. We are pleased to see that CMS is increasing oversight of agents, brokers, and web-brokers and strengthening requirements that will protect consumers upfront. This is particularly important as a consumer may incur a tax liability as a result of their information being wrongly submitted to the exchanges. Requiring agents, brokers, and web-brokers to obtain and retain documentation that a consumer verifies their information and confirms their application submission is a simple step that can curb the fraudulent practices some bad actors are engaging in for their own financial benefit and to the detriment of unsuspecting consumers.

Making Healthcare Affordable through Standardized Plans

We believe CMS is moving in the right direction with the reinstatement of standardized plans this year. However, we are concerned that the copay amounts for specialty medications remain too high for many patients struggling to afford their medications. For the approximately 45% of marketplace enrollees who are not eligible for cost-sharing reductions (CSRs) or generous subsidies that would make gold and platinum plans affordable, \$350-\$500 dollars copayments for specialty drugs is not reasonable.⁵ Research has shown that over 70% of patients will not fill a prescription when their copayment reaches \$250 (the amount proposed for specialty medications in gold level standard plans), and even at half that amount (\$125), 55% of patients will opt against filling a new prescription.⁶ CMS could make great strides in patient access by lowering the copays for specialty drugs, in particular for non-CSR silver plans and bronze plans, and by uniformly exempting all drug tiers from the deductible.

Insurers and pharmacy benefit managers have shifted more costs to beneficiaries by expanding formularies and thereby applying higher copays or coinsurance to higher tiers. We recommend against expanding the number of formulary tiers beyond the current four-tier structure to help contain patient cost-sharing. Additionally, we encourage CMS to issue guidance around the application of the specialty tier. Often medications are assigned to the specialty tier which forces the enrollee to utilize the plan's

² Federal Trade Commission, *Truth in Advertising*, <https://www.ftc.gov/news-events/topics/truth-advertising>.

³ Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, Center on Budget and Policy Priorities, (March 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

⁴ Julie Appleby, *Some Insurance Broker Enroll People in ACA Plans Without Consent*, NPR, (January 18, 2022), <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>.

⁵ US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Insurance Deductibles Among HealthCare.gov Enrollees, 2017-2021*, (January 13, 2022), <https://aspe.hhs.gov/sites/default/files/documents/748153d5bd3291edef1fb5c6aa1edc3a/aspe-marketplace-deductibles.pdf>.

⁶ IQVIA. *Medicine Use and Spending in the U.S: A review of 2018 and Outlook to 2023*. (May 9, 2019). <https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023>

specialty pharmacy in order to access their prescription; however, not all medications placed on a specialty tier require special handling. Moreover, arbitrary requirements to use specialty pharmacies create needless administrative burdens for enrollees while denying them the opportunity to work with community pharmacists whom enrollees may know and trust.

Easing Coverage Transitions

The proposed changes to special enrollment periods (SEPs) will help to ease the transition to marketplace coverage. Extending the SEP from 60 to 90 days and offering earlier effective dates for individuals losing other coverage is important to minimize any disruption in care for people with serious chronic conditions. With the anticipated ending of the Public Health Emergency (PHE) and the expiration of the Medicaid continuous coverage requirement, many people will likely be transitioning off Medicaid to marketplace plans but may have difficulty navigating the process and will need the additional thirty days. Allowing enrollees the option for an earlier effectuation date will ensure they will have uninterrupted care, which is imperative for people living with HIV to maintain adherence to treatment.

Additionally, the proposed SEP for individuals when their provider leaves the plan network mid-year would be critical for patients who rely on specialists, such as for HIV and hepatitis. People living with HIV need comprehensive and wholistic case management, and not every general practitioner is equipped to provide the specialized treatment necessary. Again, as a matter of continuous care, we believe patients for whom particular providers are integral to their health management should have the option to return to the marketplace and select a plan that has an appropriate provider in-network.

Building a Robust Provider Network

A robust provider network is an essential component of health care access. We support CMS' proposals that build on previous year network adequacy standards requiring all marketplace plans to adhere to the federal essential community provider obligations. As previously stated, specialized providers qualified to treat people living with HIV and hepatitis are becoming harder to find; however it is the insurer's responsibility to guarantee that there are the essential community providers from a variety of categories incorporated in the plan's network. While the proposals continue to expand and improve those measures of network adequacy, we believe CMS can do more to uphold and enforce the federal standards consistently across states.

Protecting Copay Assistance for Vulnerable Patients

We also note that CMS failed to address copay accumulator adjustment policies within this 2024 proposed NBPP. Copay assistance is available generally for high-cost brand and specialty medications without a medically equivalent generic alternative and is used by people with serious and complex chronic illnesses.⁷ Copay accumulator adjustment policies unfairly target people with serious, chronic illness, undermining the ACA protections that prohibit insurers from charging people with pre-existing conditions more for health insurance than healthier enrollees. These policies subvert the benefit of copay assistance, thereby discriminating against people living with chronic conditions. People with low incomes and people of color are more likely to be living with a chronic illness;⁸ therefore, these policies

⁷ K. Van Nuys, G. Joyce, R. Ribero, D.P. Goldman, *A Perspective on Prescription Drug Copayment Coupons*. Leonard D Schaeffer Center for Health Policy & Economics. (February 2018), <https://healthpolicy.usc.edu/research/prescription-drug-copayment-coupon-landscape/>

⁸ The Center for American Progress, Fact Sheet: *Health Disparities by Race and Ethnicity*. (May 7, 2020), <https://www.americanprogress.org/article/health-disparities-race-ethnicity/>

target the most vulnerable patients, enabling insurance issuers to essentially underwrite insurance policies for people who require specialty or brand medications. As CMS moves to strengthen patient protections and make health care more accessible through the other provisions of this proposed rule, we urge you to reinstate the original position as stated in the 2020 Notice of Benefit & Payment Parameters that required insurers to count payments made by, or on behalf of, an enrollee toward their out-of-pocket costs.

We appreciate HHS officials and CMS leaders making great strides to improve access and affordability of health care. Please feel free to reach out to the HHCAWG co-chairs, Rachel Klein, The AIDS Institute at rklein@tmail.org; Liz Kaplan, Center for Health Law & Policy Innovation, ekaplan@law.harvard.edu, and Marilyn Francis, AIDS United, mfrancis@aidsunited.org should you have any questions. Thank you very much for your consideration of our comments.

Sincerely,

AHF
AIDS Alabama
AIDS Alliance for Women, Infants, Children, Youth & Families
AIDS Foundation Chicago
AIDS United
American Academy of HIV Medicine
APLA Health
Center for Health Law and Policy Innovation
Community Access National Network - CANN
Community Research Initiative, Inc. (CRI)
HealthHIV
HIV Dental Alliance
HIV+Hepatitis Policy Institute
HIV Medicine Association
iHealth
International Association of Providers of AIDS Care
Lambda Legal
National Coalition of STD Directors
NASTAD
Positive Women's Network-USA
Prevention Access Campaign
San Francisco AIDS Foundation
The AIDS Institute
U=U plus
Vivent Health



January 30, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Notice of Benefit and Payment Parameters for 2024 (CMS-9899-P)

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to provide comment on the Notice of Benefit and Payment Parameters for 2024 Proposed Rule. LLS's mission is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma, and to improve the quality of life of patients and their families. We advance that mission by advocating that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare, regardless of the source of their coverage. LLS evaluates all healthcare policy proposals through the lens of our Principles for Meaningful Coverage. These principles give us an objective and constructive means of evaluating healthcare policies impacting the patients we serve.¹

We are deeply grateful for the Department's commitment to improving the availability and quality of healthcare for patients and consumers and are confident that the policies proposed here will advance our shared objectives. We offer the following comments and recommendations on specific provisions of the proposed rule:

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

LLS supports the Department's proposal to repeal the provisions that currently prohibit Navigators and certified application counselors to conduct door-to-door assistance or the use of other unsolicited means of direct contact to provide enrollment assistance to consumers. We believe that this will reduce barriers for individuals that currently have to seek appointments and go out of their daily routine to obtain enrollment assistance.

The current prohibition even limits Navigators and certified application counselors from calling a consumer without the consumer first initiating contact. The current policy places a particular burden on individuals whose travel is limited due to their health, e.g., an individual that is immunocompromised and cannot attend an enrollment outreach event or visit an office safely.

In addition, we recommend that the Department reinstate community- and consumer-focused program requirements that were eliminated when Navigator funding was scarce. Previous regulatory standards required that there be at least two navigators per state, at least one of which is a community-based nonprofit and that navigators maintain a physical presence in the state they are serving. We urge the Department to restore these important safeguards to ensure that everyone can access in-person, community-based help enrolling in marketplaces when needed.

¹ The Leukemia & Lymphoma Society. Principles for Meaningful Coverage: <https://www.lls.org/cancercost/principles>

Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

LLS supports the Proposed Rule's modest improvements to the Department's oversight of agents, brokers, and web-brokers. This includes requiring agents, brokers, and web-brokers to document that they have received consent from the consumer to provide assistance in the first place and requiring documentation that the consumer has reviewed and confirmed their eligibility information is accurate. Agents and brokers generally do not have a duty to act in the best interest of consumers and can be compensated in ways that do not align with consumer interests. For example, agent and broker compensation can include financial incentives intended to steer consumers to products that provide little to no financial protection when they need costly care. In fact, a recent Congressional investigation found that brokers received commissions for short-term limited duration insurance plans that were up to ten times higher than those for an Affordable Care Act (ACA)-compliant health plan.²

While we appreciate this step, more action is needed. We recommend the Department should take the following additional actions:

- prohibit agents and brokers that sell Qualified Health Plans (QHPs) from marketing products that are not compliant with the ACA's individual market reforms during marketplace open enrollment. These types of plans include, but are not limited to, short-term limited duration, Farm Bureau plans, and bundled products mimicking comprehensive coverage;
- require brokers, who consumers rely on for their professional experience and expertise, to act in the best interest of the individuals they serve;
- establish an affirmative duty for agents and brokers 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.³;
- require direct enrollment web brokers to display all plans in their cost comparison tools, instead of segregating plans they do not sell at the bottom of the page as is current practice; and
- establish 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.

Failure to File and Reconcile Process (§ 155.305(f)(4))

LLS urges the Department to eliminate the failure to file and reconcile process and allow the Internal Revenue Service to proceed with its normal enforcement tools. The failure to file and reconcile process has no basis in statute and was appropriately suspended for coverage years 2021 and 2022 pending backlogs of tax returns due to the COVID-19 pandemic. Consumers should not be penalized for failing to file a tax return during periods of intensive care and cutting them off from coverage when they need it most will lead to untreated health issues and more costly care later on. If the Department maintains the failure to file and reconcile process, the proposed rule is a step in the right direction. We appreciate that the Department seeks to ease

² House Committee on Energy & Commerce, *E&C Investigation Finds Millions of American Enrolled in Junk Health Insurance Plans that are Bad for Consumers & Fly Under the Radar of State Regulators*, June 25, 2020,

<https://energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>

³ Straw T. "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities, March 15, 2019. <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

the burden on consumers that have been unable to file their tax returns on time but require ongoing coverage and the benefits of advance premium tax credits (APTC).

Annual Eligibility Redetermination (§155.335)

LLS supports the Department's proposal to allow exchanges to modify their re-enrollment hierarchies to switch cost-sharing reduction (CSR)-eligible individuals in bronze plans to be automatically re-enrolled in a silver-level QHPs with CSRs of the same product or issuer with lower or equivalent premium, provided certain conditions are met. We also support the Department's proposals to incorporate net premium into the re-enrollment hierarchy broadly and begin finding ways of accounting for cost-sharing. In principle, a modified hierarchy that takes consumer costs into account, including costs that are in addition to premiums, will be more likely to match auto-re-enrolled consumers with plans best suited to their needs.

However, as the Department considers additional scenarios in which the automatic re-enrollment hierarchy can be modified to maximize consumer benefits, we urge the Department to be cautious of unintended consequences of shifting consumers to products with different provider networks. For example, while re-enrollments that place a consumer into a plan with a different network type (and a different composition of providers) may be in a consumer's best interest in some circumstances, there may just as likely be scenarios where the new network does not fit a consumer's needs. Changes in an enrollee's network generally increase the chances of confusion and out-of-network costs and could cause significant disruption to a patient's care regimen. If their primary care doctor or a key specialist is no longer in-network, this could cause ripple effects on referrals, care coordination, and/or prescription drug fulfillment and adherence. We, therefore, urge that re-enrolling someone in a plan with a different network type take place only when their current plan is being discontinued.

The Proposed Rule would allow re-enrollment into a plan with "the most similar network compared to the enrollee's current QHP," but does not provide specifics for what would be an impermissible network difference. As the Department begins to enforce and monitor the network adequacy standards newly applied to plans, LLS recommends that the Department adopt more quantitative standards related to network similarity that can be incorporated into the re-enrollment hierarchy.

Special Enrollment Periods (§§155.420(a-g))

LLS supports the Department's proposals to expand the options for special enrollment periods (SEPs) that marketplaces may offer to consumers. Additionally, the Department has recently 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.⁴ We support this policy.

Given the end of continuous eligibility requirements in the Medicaid program associated with the COVID-19 public health emergency, we are grateful for the proposals to allow marketplaces the option of providing consumers with a SEP that begins 90 days prior to coverage loss and extends 90 days after, as opposed to the 60-day window currently allowed. Similarly, we support the proposal that would allow marketplaces to require early effective dates for individuals losing minimum essential coverage to avoid partial-year coverage gaps. We urge the Department to consider making these SEPs mandatory in future years' rulemaking, or at a

⁴ Centers for Medicare and Medicaid Services, Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children's Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ), <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>.



minimum, clarify that marketplaces may already extend these SEPs beyond the required timeframes.

FFE and SBE-FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

LLS opposes the proposed reduction in exchange user fees.

The Department proposes that the 2024 user fee rates for issuers that participate on the federally facilitated exchanges (FFE) or a state-based exchange on the federal platform (SBE-FP) will be reduced from 2.75% to 2.5 and from 2.25% to 2%, respectively. This follows a pattern of a general reduction in exchange user fees that the Department has continued to follow in recent years.

While the Department notes in the preamble that increased enrollment seems to obviate the need for continued user fees to fund outreach and navigation, we caution the Department that more intense navigation needs are anticipated for the 2024 open enrollment period due to the end of the continuous eligibility requirement in Medicaid as a result of the Consolidated Appropriations Act of 2023. To help sustain recent progress in increasing marketplace enrollment, we suggest that user fee rates be returned to pre-2022 levels.

We are grateful for the extensive efforts undertaken by the Department 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. We urge the Department 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.

Standardized Plan Options, Non-Standardized Plan Option Limits (§§ 156.201, 202)

LLS strongly supports the proposal to limit the availability of non-standardized plans that insurers can offer in the marketplace to two per network type and metal level.

We agree that consumers are easily and understandably confused when they are bombarded with too many plans. This confusion can ultimately lead to choice overload. Consumers should not have to sift through an excessive number of plan designs, many of which bear no meaningful difference from each other.

However, limits on plan offerings are not a substitute for meaningful difference standards. While we appreciate the Department's discussion of reviving the meaningful difference standard, we are concerned that this is being cast as an alternative to the limit described in the proposed rule. LLS urges the Department to adopt meaningful difference standards with clear, quantitative limits that are *in addition* to the limits on non-standard plan offerings in the proposed rule.

Proposed changes to standardized plan options:

LLS applauds the Department for designing standardized options to include copays instead of coinsurance in many categories. However, the current design for prescription drug tiers is insufficient to meet the needs of blood cancer patients. We urge the Department to expand pre-deductible coverage to all tiers of prescription drugs.

As proposed, all but the gold and platinum standardized options would require consumers to meet their annual deductible, which range from \$7,400 for the expanded bronze plan to \$6,000 for the silver plan. In the standard silver option, the option theoretically meant to work the best

for all consumers, a person needing access to specialty medication must first pay a \$6,000 deductible, based on the full list price of the drug, and even after that, they would be charged \$350 per prescription until they reach a \$9,100 annual out-of-pocket limit.

LLS recognizes the difficulty that comes with designing standardized plan options that work for a wide range of consumers yet meet the needs of patients with chronic and acute conditions without imposing burdensome out-of-pocket costs. However, the proposed standard silver plans would make prescription drugs unaffordable for most patients. We realize that benefit designs must meet the actuarial value requirements in each metal level per statute. But this does not preclude other benefit designs that facilitate access to prescription drugs at lower out-of-pocket costs. Using the CMS 2024 AV calculator⁵, it is possible to achieve a similar actuarial value as the proposed standard silver plans with the following changes:

	NBPP Proposed Silver	Alternative
Specialty Drugs	\$350 after deductible	\$100 before deductible
Non-Preferred Brand Drugs	\$80 after deductible	\$70 before deductible
Preferred Brand Drugs	\$40 before deductible	\$40 before deductible
Generic Drugs	\$20 before deductible	\$25 before deductible
Actuarial Value	70.00%	69.88%

The out-of-pocket burden associated with post-deductible drug coverage will lead to patients abandoning their medications. According to a 2017 report, nearly 70% of commercially insured patients abandoned newly prescribed medication when they had to pay more than \$250 for their treatment, compared to only about 11% of patients with out-of-pocket costs of less than \$30 who left their prescriptions at the pharmacy.⁶ Even patients facing life-threatening conditions like cancer are significantly more likely to abandon their treatment than those with low-cost sharing. Indeed, cancer patients whose out-of-pocket costs are greater than \$500 are four times more likely to abandon treatment than those with cost-sharing claims of \$100 or less for a 30-day

⁵ Centers for Medicare and Medicaid Services, Draft 2023 Actuarial Value Calculator, December 12, 2022, <https://www.cms.gov/files/document/draft-2024-av-calculator.xlsm>.

⁶ IQVIA, *Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption*, May 28, 2018: <https://www.iqvia.com/locations/united-states/library/case-studies/patient-affordability-part-two>

prescription.⁷

Additionally, LLS generally supports the Department's proposal to require that standardized plan formularies include all covered generic drugs in the generic tier or the specialty tier (if there is an appropriate and non-discriminatory basis for placing it in the specialty tier) and all covered brand name drugs in a brand name drug tier (tiers 2 or 3) or the specialty tier "if there is an appropriate and non-discriminatory basis for doing so." However, we urge the Department to clarify that a non-discriminatory basis must have a clinical rationale behind it and cannot simply be a result of the drug's high acquisition cost. For example, the Department has elsewhere indicated situations where restricting drugs to a mail-order pharmacy would be permissible and non-discriminatory, i.e., if special handling, provider coordination, or patient education cannot be provided by a retail pharmacy, or if the drug's distribution is restricted by the U.S. Food and Drug Administration.⁸ This would be an example of a non-discriminatory reason to place an otherwise generic drug on a specialty drug tier.

Plan Marketing Names (156.225)

LLS strongly supports the proposal to require marketing names for QHP to include correct information and not include information about cost-sharing or benefits that is misleading. As stated above, consumers' shopping experiences should not be muddled by confusing marketing tactics and choice overload.

In particular, LLS urges the Department not to certify any marketing names for QHPs that:

- describe a limited benefit as unlimited (e.g. listing only the initial copay for a visit in the plan's name, not the standard cost-sharing amount);
- present a limited provider network as a preferred option (e.g. "choice network" or "star network"); or
- mislead consumers into believing that they can access services they cannot without significant out-of-pocket costs.

LLS also supports the proposal to establish a required format for plan marketing names with specific elements to be used for all QHPs. This would help consumers in the shopping experience by having a unified format by which to easily sort and compare plans. This could include basic information such as the issuer name, metal level, deductible (either in dollars or high/low with specific ranges set by the Department), health savings account eligibility, and limited cost-sharing information such as the copay for primary care physician visits.

Plans That Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

Federal Review of Network Adequacy

LLS is grateful that the Department continues to mandate federal oversight and review of network adequacy standards for plans offered through the federally-facilitated exchanges. However, we urge the Department to go further by extending these requirements to all marketplace plans.

⁷ Blesser Streeter, S. et al., *Patient and Plan Characteristics Affecting Abandonment of Oral Oncolytic Prescriptions*, Journal of Oncology Practice, 2011 <https://ascopubs.org/doi/10.1200/JOP.2011.000316>

⁸ 45 C.F.R. § 156.122(e)(1).

LLS shares the Department's concern about the lack of consistency in network adequacy regulatory approaches across states. While states have slowly gravitated towards the use of quantitative standards, regulatory approaches remain highly fragmented. This is even though network regulation and narrow networks pose common challenges across jurisdictions. We believe strongly that a marketplace consumer's ability to access an adequate network of providers should not depend on what state they live in. We, therefore, support the adoption of the current federal baseline quantitative standards for all marketplaces, federal and state-run alike. This would create unified standards for access to two classes of oncologists (medical/surgical and radiation) and achieve closer alignment to standards in the Medicare Advantage program.

Network Adequacy Standards

LLS supports the Department requiring insurers to submit a set of quantitative data, rather than mere attestations, to demonstrate compliance with network adequacy standards. However, LLS urges the department to broaden the standards insurers must meet to ensure that patients have timely, meaningful access to the care and services they need.

Network adequacy standards for oncology care continue to be defined broadly, without the level of specificity needed to ensure the availability of subspecialty blood cancer care. There are no network standards for disease-specific specialty care, including blood cancer specialty care.

Access to cancer care at a small general hospital or community oncology clinic is not the same as access to centers that specialize in treatments for certain serious diseases. Some treatments available to blood cancer patients are typically only available at a small number of specialized cancer care providers, including academic medical centers, National Cancer Institute (NCI)-designated cancer centers, and some community-based providers with large and advanced cancer programs.

In many states, these providers are excluded from plan networks: A survey of 29 NCI-designated centers found that 93% are out of network for some or all QHP issuers in their state, with coverage varying significantly by state.⁹ In addition, 14 states do not have an NCI-designated cancer center or other equivalent located in-state. These factors combined mean that in order to access medically necessary blood cancer care, patients must often need to access care not available in their plan's network or possibly in their state.

As detailed in our recent *Vital Access* report, some states have recognized the importance of access to these centers for cancer patients. For example, New York has established an "any willing provider" requirement for NCI-designated cancer centers. This requires any NCI-designated center willing to contract at reasonable rates to be included in-network in both Medicaid managed care plans and individual market plans.¹⁰ We urge the Department to consider adopting a similar policy for QHPs.

⁹ Schatz A, Winckworth-Prejsnar K. Survey of NCI-Designated Cancer Centers Finds Most Are Out-of-Network on Exchanges, *American Journal of Managed Care* (2018), <https://www.ajmc.com/view/survey-of-ncidesignated-cancer-centers-finds-most-are-outofnetwork-on-exchanges>; The Leukemia & Lymphoma Society, Accessing Out-of-Network Subspecialty Cancer Care in Marketplace Plans (June 2021), <https://www.lls.org/sites/default/files/2021-06/Network-Adequacy-June-2021-Final.pdf>.

¹⁰ The Leukemia & Lymphoma Society, *Vital Access: How Policymakers Can Streamline the Cancer Care Journey* (Jan 2023), https://www.lls.org/sites/default/files/2023-01/vital_access_2023.pdf



Appointment Wait Time Standards

LLS is concerned that the Department proposes to implement appointment wait time standards simply by letting insurers attest to compliance. We request that the Department conduct, or require insurers to conduct via third-party auditors, direct tests of compliance during the plan year. Taking affirmative steps to monitor QHP networks is more likely to reveal problems and facilitate timely remediation than a reactive approach focused only on attestation and complaint reporting. This is in line with the enforcement approach the Department is taking with respect to time and distance standards, i.e., requiring affirmative proof of compliance and not just an attestation from issuers.

Network-less plans

LLS supports the Department's proposal to remove the exception to network adequacy requirements for plans that do not use a provider network. We agree with the Department that a plan without a network cannot satisfy the statutory requirements of the ACA that plans provide access to essential community providers "within their plan networks" and ensure an otherwise sufficient choice of providers.¹¹

Conclusion

Thank you again for the opportunity to comment on the Notice of Benefits and Payment Parameters for 2024 Proposed Rule. If you have any questions or would like to discuss our comments further, please contact Phil Waters, Director of Federal Public Policy at The Leukemia & Lymphoma Society at phil.waters@lls.org.

Sincerely,

Bethany Lilly
Executive Director of Public Policy

¹¹ ACA §§ 1311(c)(1)(B), 1311(c)(1)(C).



Ref: 2022-27206 CMS Comment Period related to:

CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

**Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information &
Insurance Oversight at the Centers for Medicare and Medicaid Services**

We are writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21, 2022. We appreciate the opportunity to provide comments on this important proposed rule.

Health Agents for America, Inc. "HAFA" is a trade organization representing independent Health Insurance Agents in all fifty (50) States. HAFA was formed in November 2012 to answer a need for independent Health Insurance Agents, provide exclusive representation, in order to address important matters such as commissions, the ACA and our inclusion in the Federal and State Marketplaces. HAFA's Mission is to be the leading advocacy association representing the interests of licensed insurance professionals in Washington, DC and every state capitol.

We have thoroughly evaluated the proposed rule and have comments to offer regarding the following topics.

- No Binder Payment – Zero Premium Remapping
- Section 155.106 State Waiver Timelines
- Section 155.210(d)(8) Navigator Marketing
- Section 155.305 Failure to Reconcile Extension
- Section 155.315/155.320 Income Attestations
- Section 155.335 Annual Mapping
- Section 155.420 Mid-Month SEP
- Section 155.420(d) Provider Network Change SEP
- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

No Binder Payment – Zero Premium Remapping

The first topic we would like to cover is the proposal to move consumers to a zero-premium plan in the event the consumer enrolls in a qualified health plan during open enrollment but fails to pay their premium.

We would like to express our concerns about the proposal to automatically move consumers who do not pay their

binder payment by the deadline to a zero-premium plan. While we recognize that the zero premium plan may be more affordable for some consumers and provide a safety net for those at risk of losing coverage, there are also several potential drawbacks to this proposal.

One concern is that the automatic switch to a zero premium plan could be confusing and disruptive for consumers, who may not have been expecting to be enrolled in a different plan. The new plan may not offer the same coverage or provider network as the original plan, which could cause difficulties for consumers who are already receiving care or have established relationships with certain providers.

Additionally, consumers may not have a choice in whether to switch to the zero-premium plan, even if they prefer their original plan or are able to pay their binder payment at a later date. This could limit their ability to make informed decisions about their healthcare coverage.

Finally, in previous years, we have noted that the accuracy and timeliness of outstanding premiums have not always been accurate. Consumers may make a binder payment, but if the data isn't shared from the carrier to the marketplace either accurately, or by the deadline, the consumer may be mapped to another plan causing further confusion.

Overall, while we recognize the potential benefits of the zero-premium plan, we believe that it is important to carefully consider the potential drawbacks and ensure that consumers have the ability to make informed decisions about their healthcare coverage.

Section 155.106 State Waiver Timelines

Next, we would like to express our concern about the current timeline for states to transition to the ACA marketplace. As outlined in section 155.106, states are required to have 3-14 months (depending on type of waiver) from the time CMS greenlights their transition to when their system can be live for open enrollment. We believe that this timeline is insufficient, and that CMS should have more time to properly prepare for this transition. We believe, as markets transition away from FFM, and states need more ramp up time to iron out kinks.

There are several reasons why we believe that CMS and states should have more time to transition to their SBM marketplace. First and foremost, this will help individuals to have more time to prepare for this transition. Many individuals rely on the ACA marketplace for their healthcare coverage, and a rushed transition could lead to confusion and uncertainty for these individuals. By giving states more time to transition to the SBM marketplace, individuals will have the opportunity to better understand what the shift means.

Additionally, more time for the transition will benefit insurers and enrollers as well. Insurers and enrollers need time to prepare for the transition to the state's marketplace, including updating their systems and processes to comply with the new requirements. A core tenant of the SBM waiver is for states to show how their unique approach to the market would save federal funds. This "unique" autonomy adds additional considerations for insurers and enrollers as state level rule making varies from FFM rules. A rushed transition could lead to delays and difficulties for these stakeholders, which could ultimately impact the quality of care and coverage that individuals receive. By giving states more time to transition to the SBM marketplace, insurers and enrollers will have the opportunity to properly prepare and ensure that they are able to provide high-quality care and coverage to individuals.

In conclusion, we strongly believe that CMS and states should take more time to transition to SBM marketplaces. This will help individuals, insurers, and enrollers to have more time to prepare for this transition and ensure that the marketplace is able to function effectively and efficiently. We encourage CMS to consider extending the timeline for the transition to the State marketplaces to allow for a smoother and more successful transition.

Section 155.305 Failure to Reconcile Extension

Next, we'd like to express our thoughts on the potential change to Section 155.305 of the ACA, which currently requires exchanges to remove premium tax credits (PTCs) if the IRS determines that an individual did not reconcile their PTCs for the previous year.

One potential pro of changing the rule to a two-year period is that it could give individuals more time to reconcile their PTCs and avoid having to pay back any excess credits. This could be particularly beneficial for individuals who have complex financial situations or who have difficulty navigating the process of reconciling their PTCs. In addition, such a change could help to prevent situations where individuals have filed an extension with the IRS in April and have not yet filed their return by the time the IRS reviews PTCs, resulting in the exchange removing PTCs even though the individual's tax situation may ultimately be found to be in compliance.

However, we also recognize that there are potential cons to changing the rule to a two-year period. One concern is that a two-year reconciliation period could lead to more instances of fraud or abuse, as individuals may be able to receive excess credits for a longer period of time before they are detected and required to pay them back.

One further consideration is that for individuals who exceed 400% of the federal poverty limit, the amount of PTCs they could be subject to pay back could be much higher than for lower income households, and a two-year reconciliation period could result in a higher repayment effect for these individuals.

In conclusion, we believe that the decision to change the rule from a one-year to a two-year period should be carefully evaluated, taking into account the balance of the potential pros and cons as well as the specific circumstances and needs of the individuals and small businesses participating in the exchanges.

Section 155.315/155.320 Income Attestations

Next, we'd like to provide comments on the use of attestation in the ACA Health Insurance Marketplace to address income inconsistencies. Section 155.315 and 155.320 of the Affordable Care Act (ACA) relate to income inconsistencies when an individual is applying for coverage through the exchange. These provisions require that the exchange verify an individual's income in order to determine their eligibility for premium tax credits and other cost-sharing reductions.

One option for addressing income inconsistencies is for the exchange to accept an attestation from the consumer, in which they affirm that their projected income for the coming year will be different from their prior year income. While this approach has the potential to be more streamlined and efficient, and may be more convenient for the consumer, there is a risk that the consumer's attestation may not accurately reflect their actual income for the coming year. Additionally, if the exchange relies solely on an attestation and does not verify the consumer's projected income, it may be more vulnerable to fraud or abuse.

Overall, it may be necessary to balance the convenience and efficiency of accepting an attestation with the need to ensure accuracy and prevent fraud. In states, like Maryland, we have seen an attestation with a space to explain why prior electronic data of income, and prior tax documents may not reflect upcoming income. This would strike a balance between the risk and reward as consumers will not only attest to their projected MAGI but offer an explanation as to WHY it is changing. Events like having a child, retirement, self-employed income swings, and many other life events routinely cause MAGI changes that can be explained within the attestation.

Section 155.335 Annual Mapping

Section 155.335 of the Affordable Care Act (ACA) relates to the annual process of redetermination, which involves reviewing an individual's eligibility for premium tax credits and cost-sharing reductions (CSR) and determining the appropriate level of assistance. This provision currently requires the exchange to map individuals to different plans based on their income and household size, as well as other factors such as their tobacco use and any special enrollment

circumstances.

If CMS were to change this provision to include network IDs, net premium, maximum out-of-pocket (MOOP), and CSR in the mapping process, it could have some potential pros and cons:

Pros:

Adding these factors to the mapping process could provide a more comprehensive and accurate assessment of an individual's needs and preferences. Network IDs, for example, could be helpful in determining whether a particular plan is a good fit for an individual based on their access to preferred providers.

Including net premium and MOOP in the mapping process could help ensure that individuals are enrolled in a plan that is affordable and meets their financial needs.

Incorporating CSR in the mapping process could help ensure that individuals receive the appropriate level of assistance based on their income and other factors.

Cons:

Adding more factors to the mapping process could make it more complex and time-consuming for the exchange to develop multiple use cases to find the appropriate plan for an individual. This could lead to delays in the redetermination process.

It could also be more challenging for individuals to understand and navigate the mapping process if there are more factors to consider and it isn't clear from the prior plan to the new plan, which variables are the most prudent.

There may be additional administrative and logistical challenges involved in implementing these changes, which could impact the overall efficiency and effectiveness of the redetermination process.

Section 155.420 Mid-Month SEP

Section 155.420 of the Affordable Care Act (ACA) relates to special enrollment periods (SEPs), which allow individuals and families to enroll in a health insurance plan outside of the annual open enrollment period. According to this provision, the start date for an SEP is typically the month following the event or enrollment, whichever is later. This means that if an individual experiences a qualifying event (such as a change in employment status or a move to a new area) that allows them to enroll in a new plan through an SEP, their coverage will typically begin the month after the event or their enrollment date, whichever is later.

Allowing the start date for an SEP to be whichever is earlier (rather than whichever is later) could potentially have some pros and cons:

Pros:

Allowing consumers to enroll on the first of the month that has a loss of coverage mid-month could allow them to get coverage sooner in some cases. For example, if an individual experiences a qualifying event in the middle of the month and enrolls in a new plan through an SEP, their coverage would typically start the following month under the current rules. Removing this requirement could allow their coverage to start earlier, potentially reducing any gap in coverage.

This change could also help ensure that individuals have access to timely and continuous coverage, which is important for their overall health and well-being.

Cons:

Making this change, however, could result in individuals enrolling in a new plan earlier than they intended or were aware of. For example, if an individual experiences a qualifying event and enrolls in a new plan through an SEP but does not realize that their coverage will start immediately, they may end up paying premiums for coverage they do not need.

This change could also potentially result in confusion or misunderstandings about when coverage will begin, which could lead to issues with billing and payment.

Allowing the start date for an SEP to be whichever is earlier could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

Overall, it's important to carefully consider the potential pros and cons of allowing the start date for an SEP to be whichever is earlier before making any changes to this provision. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

Section 155.420(d) SEP for Network Changes

The Centers for Medicare and Medicaid Services (CMS) is proposing a change to section 155.420(d) of the Affordable Care Act (ACA) that would create a special enrollment period (SEP) for individuals who are enrolled in a qualified health plan (QHP) and whose provider is no longer in network during the plan year.

This change could potentially have some pros and cons:

Pros:

Creating an SEP in this situation could allow individuals to enroll in a new QHP that includes their provider in its network, which could be important for maintaining access to care. This could be particularly beneficial for individuals who have ongoing medical conditions or needs that require ongoing treatment from a specific provider.

An SEP could provide a more flexible and responsive solution to changes in provider networks, as it allows individuals to enroll in a new plan if their provider is no longer in network.

Cons:

Creating an SEP could potentially lead to disruptions in coverage and additional administrative burden for individuals, as they would need to enroll in a new plan and potentially switch to a new provider. This could also be disruptive for providers, as they may need to transfer medical records and establish a new care relationship with the individual.

An SEP could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

One alternative approach to addressing provider network changes could be to require the provider to accept in-network rates through the end of the plan year. This approach could have some pros and cons as well:

Pros:

Requiring the provider to accept in-network rates through the end of the plan year could help ensure that individuals have continuous access to care without the need to switch providers or enroll in a new plan.

This approach could also reduce administrative burden for individuals and providers, as it would not involve enrolling in a new plan or transferring medical records.

Cons:

Requiring the provider to accept in-network rates may not be feasible in all cases, depending on the terms of the provider's contract with the insurer.

This approach could potentially result in financial implications for the provider, as they may not receive their usual reimbursement rate for the services they provide.

It could also have financial implications for the insurer, as they may need to pay higher rates to the provider in order to ensure that individuals have access to care.

Another Alternative Approach is requiring provider and insurer contracts to run on a calendar year basis and finalized before the plan year open enrollment period. This, also, could potentially have some pros and cons:

Pros:

Having provider and insurer contracts run on a calendar year basis could potentially provide more stability and predictability for individuals, as their coverage would be aligned with the calendar year. This could make it easier for individuals to understand and plan for their healthcare needs and expenses.

A calendar year basis could also provide more clarity and consistency for providers, as their contracts would be aligned with the same timeframe. This could potentially reduce administrative burden and make it easier for some providers to plan for their practice.

Aligning provider and insurer contracts with the calendar year could also potentially make it easier to track and report on healthcare utilization and costs, as there would be a clear and consistent timeframe for these metrics.

Cons:

Requiring provider and insurer contracts to run on a calendar year basis could potentially result in disruptions or gaps in coverage for individuals if they experienced a qualifying event that would normally trigger an SEP. For example, if an individual experiences a change in employment status or a move to a new area during the middle of the year, they may not be able to enroll in a new plan with their care team until the following year.

This approach could also potentially create financial challenges for providers, as their contracts would be limited to a calendar year timeframe. This could make it difficult for some providers to plan for their practice and manage their financial resources.

It could also have financial implications for insurers, as they may need to adjust their rates and premiums to align with a calendar year basis.

Overall, it's important to carefully consider the potential pros and cons of requiring provider and insurer contracts to run on a calendar year basis before making any changes. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FFs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.
- **Section 155.220(j)(2)(ii)(A)**
 - I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
 - I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
 - An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information
- **Section 155.220(j)(2)(ii)(A)(1)**
 - To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
 - I am concerned with the words, "under penalty of perjury." I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professional hold myself to the highest regard of integrity.
 - I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
 - Please keep in mind, many consumers do not have access to computers, most have access to phones.
 - With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

- **Section 155.220(j)(2)(ii)(B)**

- This section is speaking about an issue that is happening across the nation to many professionals.
- I know colleagues who have had a “rouge” agent steal their clients.
- Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
- This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
- Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
- When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
- Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
- We need help in this area but requiring additional paperwork doesn’t seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to HAFA and the Agent/Broker Industry

Sincerely,

Ronnell

B. Ronnell Nolan, HIA



January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-9899-P, ACA Proposed Notice of Benefit and Payment Parameters for 2024

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to submit comments on the Proposed Notice of Benefit and Payment Parameters for 2024. We are supportive of the proposals set forth in the Notice and applaud the continued efforts of CMS to expand access to, and enrollment in, quality, affordable, health insurance coverage—especially for the more than 5 million Americans aged 50-64 who get their coverage through an exchange.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Program Standards

AARP has long supported efforts by CMS to improve and expand opportunities for enrollment in health insurance coverage. Navigators and assisters have provided nonbiased, local in-person assistance across the country to help consumers navigate, shop, and enroll in health insurance coverage through an exchange marketplace. In addition, these groups and individuals play a vital role in helping consumers prepare electronic and paper applications to establish eligibility, complete enrollment documentation, and potentially qualify for premium financial assistance (APTCs) or out-of-pocket cost assistance (CSRs).

We support the proposals to require agents, brokers, or web-brokers assisting with enrollment and/or financial assistance applications through the federal or state/federal partner marketplace to document that application information has been reviewed and confirmed to be accurate by the consumer prior to submission. As noted in the proposal, incorrect consumer information that is submitted by an agent or broker and not verified can result in consumers receiving inaccurate eligibility determinations and can adversely impact their tax liability. While the rule proposes that this information be retained by agents and brokers for no less than 10 years and be produced upon request by CMS, we recommend that CMS consider random, periodic audits on a regular basis. This would enable CMS to more proactively provide oversight of this process and address any obstacles that may remain to ensure accurate enrollment information.

Special Enrollment Periods

Special enrollment periods (SEPs) are important because they provide consumers with protection from gaps in coverage by allowing them to enroll when they experience major life changes outside of open enrollment periods. This proposed rule continues previous efforts to expand the availability of SEPs and improve access to health insurance coverage when it is needed.

We are supportive of the proposals meant to further remove barriers to coverage due to life events. The proposal clarifies that only one person in a household (including a dependent) would need to qualify for a SEP in order for the entire family to qualify and expands the window of notification of a life event (and therefore eligibility for a SEP) from 60 days to 90 days. These changes will help to ensure that families will not have to face additional hurdles in maintaining coverage during potentially traumatic life events and remove yet another barrier to ensuring access to quality, affordable coverage. We likewise support the proposal to permit insurance marketplaces to allow consumers up to 90 days after loss of Medicaid or CHIP coverage to select a marketplace plan and to offer earlier effective start dates. This will help create a smoother transition between insurance affordability programs and minimize potential coverage gaps, especially important with the upcoming unwinding of the public health emergency and Medicaid eligibility redeterminations.

Standardized Plans

We are encouraged by CMS's commitment to standardized plan options and proposals to refine the proposal we supported last year requiring all insurance carriers that offer Qualified Health Plans (QHPs) through exchange marketplaces to also offer standardized options. Standardized options enhance enrollee experience, increase understanding of plan options, simplify the plan selection process, combat discriminatory plan designs, and advance health equity.

AARP supports a well-balanced formulary design that enhances quality, conserves resources, and ensures consumer access to the prescription drugs they need. If CMS considers adding tiers to the formulary design for standardized plans in the future, we recommend first considering the impact that additional tiers, including associated cost sharing, would have on access and affordability for adults ages 50 to 64 enrolled in these plans.

In addition, with respect to formulary tiers, AARP has long been concerned by mixed tier composition. When plans put generic drugs on brand tiers and brand drugs on generic tiers, it can make it extremely challenging for consumers to understand their drug formulary. AARP strongly urges CMS to monitor tier composition for standardized plans to ensure that enrollees are not paying prohibitively high cost-sharing for expensive covered drugs and that tier labels are as accurate as possible. We also encourage CMS to continue exploring ways to improve affordability and make the overall enrollment process more manageable by considering ways to limit the overall number of QHPs offered in any given exchange marketplace.

Stand-Alone Dental Plans

AARP supports proposals meant to improve consumer understanding of, and access to, stand-alone dental plans. The proposal to streamline the use of age in determining a stand-alone dental plans' rate by insurance carriers will help eliminate unnecessary complexity for both consumers and the Navigators and assisters who help them.

We also support the proposal to, beginning in plan year 2024, require insurance carriers offering stand-alone dental plans to submit guaranteed plan rates for approval to respective state Departments of Insurance prior to sale on an insurance marketplace. This will eliminate the practice of providing estimated rates to consumers that typically require the enrollee to contact the insurance carrier directly to determine a final rate. As with the previous proposal, this will ensure that consumers and those who assist them will better understand their coverage and the actual premium costs they will incur.

Essential Community Providers

Essential community providers (ECPs) are critical resources of health care to predominantly underserved populations. They include such services as Indian Health Services, Federally Qualified Health Centers (FQHCs) and Ryan White AIDS providers. Under the ACA, plans are required to have enough ECPs— 35 percent of available ECP's in each plan's service area — within their provider networks. AARP is supportive of the proposal to establish two new ECP categories to better serve the needs of enrollees: Mental Health Facilities and Substance Use Disorder (SUD) treatment centers. We believe that the inclusion of these provider facilities moves us closer to the shared goal of removing barriers to accessing quality health care, especially for older Americans.

Once again, we appreciate the opportunity to share our comments on the proposed rule. If you have any questions, please do not hesitate to contact me, or have your staff contact Brendan Rose on our Government Affairs Team at 202-434-3770 or brose@aarp.org.

Sincerely,



David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs



350 Winter St. NE
Salem, OR 97301
503-378-4100

500 Summer St. NE
Salem, OR 97301
503-947-2340

January 30, 2023

Submitted Electronically Only: <http://www.regulations.gov>

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: **CMS-9899-P**

Greetings:

This letter comes to you on behalf of the State of Oregon Department of Consumer and Business Services, Oregon's insurance regulator, and the Oregon Health Authority, the agency housing the Oregon Health Insurance Marketplace (OHIM) – Oregon's state-based exchange on the federal platform (SBE-FP). We send this letter to comment on the proposed Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 (NBPP), issued on Dec. 12, 2022, and published in the Federal Register on Dec. 21, 2022.

We appreciate the work the Department of Health and Human Services (HHS) did to release the NBPP earlier than in prior years. We also thank HHS (we assume in response to our comment on the 2023 NBPP) for avoiding a release date that falls in the week before, during, or after the Thanksgiving, Christmas, or New Year's Day holidays when many staff members are scheduled to be out of the office.

While better than previous years, we continue to urge HHS to provide the full 60-day comment period to which we are entitled. 49 days from public exposure and 39 days from publication in the Federal Register for public review and comment is insufficient, given the number of policy and process changes that must be carefully considered – not only on their own merits – but also for their potential impact on other regulations and state laws. Not only does Executive Order 12866 ("each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days") require a 60-day comment period due to the complexity of the NBPP, as a practical matter, a 60-day comment period is necessary for the states and other concerned parties to provide well-informed and thoughtful comments.

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2023

A. Part 153 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

1. Sequestration

Oregon has no comment on this proposal.

2. HHS Risk Adjustment (§ 153.320)

a. Data for Risk Adjustment Model Recalibration for 2024 Benefit Year

Oregon supports the proposed approach to recalibrating HHS's risk adjustment models for 2024. Of the options presented, we agree that option 4 strikes the best balance between maintaining HHS's established practice of recalibrating the models based on the three most recent years of available EDGE data while also making a necessary adjustment to account for the anomalous decreases in the age/sex coefficients observed during the 2020 benefit year.

b. Pricing Adjustment for the Hepatitis C Drugs

Oregon supports continuing to apply a market pricing adjustment to plan liability associated with Hepatitis C drugs in the risk adjustment models.

c. Request for Information: Payment HCC for Gender Dysphoria

- The implications of using the changing clinical concepts and labels from the ICD-10-CM diagnosis of "gender identity disorder" compared to the draft ICD-11-CM diagnosis of "gender incongruence" for the naming and inclusion of this diagnosis or payment HCC in the HHS risk adjustment models.
- Whether a gender dysphoria HCC should be a separate and standalone payment HCC, or if gender dysphoria could be combined with any other diagnoses to form a broader payment HCC.
- Any other factors HHS should consider when determining whether to add a gender dysphoria HCC to the HHS risk adjustment models as a payment HCC.

As one of the first states in the nation to require health insurance plans to cover medically necessary treatment for gender dysphoria, Oregon supports adding a payment HCC for gender dysphoria to the HHS-operated risk adjustment model and provides the following comments in response to the request for information on this issue.

In 2012, the Oregon Division of Financial Regulation (then known as the Oregon Insurance Division) issued Insurance Bulletin 2012-1. Among other things, Bulletin 2012-1 prohibited an insurer from discriminating against an enrollee on the basis of actual or perceived gender identity and prohibited categorical exclusions based on gender identity. Four years later, the division issued Bulletin 2016-1, which reiterated the previous guidance and established specific expectations for health insurers. Looking ahead, we anticipate the introduction of legislation that would codify the division's guidance into the Oregon Revised Statutes. We expect that many other states will follow suit in the coming years and that coverage for gender affirming care will become increasingly common throughout the country.

Accordingly, Oregon believes it is appropriate for HHS to establish an HCC for gender dysphoria and that any such HCC should align with the conceptual framework supporting the draft ICD-11-CM diagnosis of “gender incongruence” and should avoid stigmatizing terms such as “disorder.” As discussed in the development of the ICD-11 definitions, gender dysphoria is increasingly being understood as a matter of sexual health rather than a mental health condition. Accordingly, any new HCC should recognize this distinction as well.

d. List of Factors to be Employed in the Risk Adjustment Models (§ 153.320)

Oregon has no comment on this proposal.

e. CSR Adjustments

Oregon supports the proposal to continue using the same cost-sharing reduction (CSR) adjustment factors that have been used since 2019.

f. Model Performance Statistics

Oregon has no comment on this section.

3. Overview of the HHS Risk Adjustment Methodology (§ 153.320)

Oregon has no comment on this proposal.

4. Repeal of Risk Adjustment State Flexibility to Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))

a. Repeal of State Flexibility to Request Transfer Reductions

Oregon supports maintaining state flexibility to request risk adjustment transfer reductions. While Oregon has not exercised this flexibility to date, Oregon believe states should continue to have this ability in the rare instances when the federal risk adjustment methodology may not be appropriate for a particular state market.

b. Request to Reduce Risk Adjustment Transfers for the 2024 Benefit Year

Oregon has no comment on this proposal.

5. Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700 and 153.710)

a. Collection and Extraction of the QSEHRA Indicator

Oregon supports adding a QSEHRA indicator to the risk adjustment data set and agrees that collecting and extracting this information will be helpful in understanding the actuarial characteristics of the health reimbursement (HRA) population and in determining how and whether HRA enrollment is impacting state risk pools. Oregon supports the transitional approach discussed in the preamble, under which issuers would be allowed to populate the QSEHRA indicator with information they already have available during the 2023 and 2024 benefit years and then being required to make a good faith effort to capture QSEHRA information starting with the 2025 benefit year. Oregon believes a phased implementation is necessary to allow issuers sufficient time to adapt to the new collection requirements and to implement processes necessary to collect this information accurately.

b. Extracting Plan ID and Rating Area

Oregon supports the proposal to have HHS extract plan IDs and rating area data elements from the 2017 through 2020 benefit year data submissions and agrees that having this data available will aid in annual model recalibration and other analyses of risk adjustment data, including identifying historical trends.

6. Risk Adjustment User Fee for 2024 Benefit Year (§ 153.610(f))

Oregon has no comment on this proposal.

7. Risk Adjustment Data Validation Requirements when HHS Operates Risk Adjustment (HHS-RADV) (§§153.350 and 153.630)

Oregon has no comment on this proposal.

B. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

1. Exchange Blueprint Approval Timelines (§ 155.106)

Oregon supports this proposal because as noted, removing the 14-month hard deadline gives greater flexibility to states transitioning to SBE-FPs or full state-based exchanges (SBEs).

2. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

Oregon supports the proposed rule on the repeal of prohibitions on door-to-door and other direct contacts. HHS proposes to repeal the provisions that currently prohibit navigators, certified application counselors, non-navigator assistance personnel in FFEs, and non-navigator assistance personnel in certain state exchanges funded with section 1311(a) exchange establishment grants (collectively, assisters) from going door-to-door or using other unsolicited means of direct contact to provide enrollment assistance to consumers. This proposal would eliminate barriers to coverage access by maximizing pathways to enrollment. Oregon agrees that in certain communities, this may be a more effective way of reaching people and disseminating information.

3. Ability of States to Permit Agents and Brokers and Web-brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

a. Extension of Time to Review Suspension Rebuttal Evidence and Termination Reconsideration Requests (§ 155.220(g) and (h)).

Oregon supports the proposed rule to allow HHS up to an additional 15 or 30 calendar days to review evidence submitted by agents, brokers, or web brokers to rebut allegations that led to suspension of their exchange agreement(s) or to request reconsideration of termination of their exchange agreement(s), respectively. Oregon also appreciates the recognition of the potential hardships faced by agents and brokers and encourages HHS to implement all possible procedures to minimize this burden.

b. Providing correct information to the FFEs (§ 155.220(j))

Oregon supports the proposed rule to amend § 155.220(j)(2)(ii) to require agents, brokers, or web-brokers assisting with and facilitating enrollment through FFEs and SBE-FPs or assisting an individual with applying for advance premium tax credits (APTCs) and CSRs for qualified health plans (QHPs) to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or their authorized representative designated in compliance with § 155.227, prior to application submission. While Oregon agrees that there is a need for documentation for the proposed rule, Oregon is concerned that the requirements imposed by the rule will be too onerous for consumers, agents, brokers, and web-brokers. Specifically, Oregon has concerns that the written or verbally recorded acknowledgement may be difficult to obtain and maintain under certain circumstances, such as when assistance is provided via the telephone. In addition, the requirement that agents and brokers store the required documentation for ten years could create a significant hardship for some agents and brokers with more limited capacity. This could create barriers and keep some agents from participating in the exchange, potentially leading to new equity and service gaps for some communities that are already being harmed by health insurance assistance-related inequities.

c. Documenting receipt of consumer consent (§ 155.220(j))

Oregon supports this proposal to document receipt of consent from the consumer to assist. However, Oregon has concerns that the increased documentation and records maintenance requirements may discourage participation of some agents/brokers in the exchange. Marketplace/individual health insurance coverage is the least stable line of business for most insurance agents. Agents and brokers with large books of group and non-exchange business may determine that the additional requirements are too burdensome and stop assisting exchange enrollees. Agents and brokers with smaller books of business, especially those in rural areas, may not have the ability to implement the new requirements and be forced to stop helping exchange enrollees.

To implement the proposals noted above, has HHS considered embedding an online repository to enter the required data into the current application? Oregon suggests that HHS consider doing so, or in the alternative, provide a different location for agents and brokers to upload this information. Oregon believes that either implementation strategy could alleviate the burden on smaller agents and brokers, many of whom serve communities that are subject to assistance and access-related inequities, and larger agents and brokers to maintain the required records.

4. Eligibility Standards (§ 155.305)

a. Failure to File and Reconcile Process (§ 155.305(f)(4))

Oregon supports the proposal to terminate APTCs after two consecutive years of a consumer's failure to reconcile (FTR) their taxes rather than after one year. Oregon agrees with HHS's assessment that the proposal will help consumers avoid gaps in coverage while at the same time minimize the potential for much larger tax bills incurred for several years of FTR. Finally, Oregon agrees that the proposal remedies issues resulting from out-of-date tax filing information that would otherwise unjustly cause a consumer to lose their APTCs.

b. There is no 4.b. To reduce confusion and make commenting easier in future NBPPs, Oregon requests that HHS not assign a lettered subsection to numbered single sections. Alternatively, Oregon requests that HHS reserve the second lettered subsection of a numbered section when only one lettered subsection contains content. For example, because there is no subsection b.,

section 4 should have been written as, “4. Eligibility Standards (§ 155.305) – Failure to File and Reconcile Process (§ 155.305(f)(4)),” or HHS should have added a subsection b as follows: “b. Reserved.”

5. Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

a. Income Inconsistencies

Oregon supports the proposal for HHS to accept a consumer’s attestation of projected annual household income when IRS tax return data is unavailable. Oregon agrees that this approach is a fairer way to determine eligibility for consumers and that it will reduce the administrative burden on exchanges and barrier to entry for consumers. Oregon suggests that HHS calculate the resulting administrative savings and ensure that it is factored into SBE-FE and FFE assessment calculations.

Oregon also supports the proposal to automatically extend the time for consumers to provide documentation to verify household income by 60 days. Oregon believes the benefits to traditionally disproportionately impacted communities alone justify the proposed change.

b. There is no 5.b. To reduce confusion and make commenting easier in future NBPPs, Oregon requests that HHS not assign a lettered subsection to numbered single sections. Alternatively, Oregon requests that HHS reserve the second lettered subsection of a numbered section when only one lettered subsection contains content. For example, because there is no subsection b., section 4 should have been written as, “4. Eligibility Standards (§ 155.305) – Failure to File and Reconcile Process (§ 155.305(f)(4)),” or HHS should have added a subsection b. as follows: “b. Reserved.”

6. Annual eligibility redetermination (§ 155.335)

While Oregon appreciates the idea of helping consumers by moving them to cost-sharing reduction (CSR) plans, we oppose the proposal to move CSR-eligible bronze enrollees to silver plans at re-enrollment primarily because this change would benefit only a very small number of Oregon enrollees, while leaving enrollees in similar circumstances in their current bronze plans. In Oregon, where consumers have access to more than two carriers in every service area, only consumers enrolled in bronze plans offered by the carrier that offers the lowest-cost silver plan would have access to silver CSR plans with premiums at or below bronze plan premiums. In some areas, the second lowest-cost silver plan would also have lower premiums than some bronze plans. While consumers who are CSR-eligible have access to \$1 bronze plans from every carrier, only those with incomes below 152 percent of the federal poverty level (FPL) also have access to \$1 silver plans – generally only from the lowest-cost silver plan. This means that there will be bronze enrollees who have access to more affordable CSR plans at similar premiums, but who are not auto-enrolled in them because they are not currently enrolled with that carrier. There are also some counties where all silver plans are more expensive than bronze plans, resulting in no enrollees being eligible for the proposed auto-enrollment. This is complicated for agents and assisters to explain, for carriers to explain and administer, and for consumers to understand. If HHS moves forward with this proposal over Oregon’s opposition, it should broaden the proposal to include enrollees in gold plans. The 87 percent and 94 percent CSR plans offer better cost-sharing, often at lower premiums, and would better serve consumers in those income groups.

Oregon also opposes HHS's proposal to change the reenrollment hierarchy to include out-of-pocket costs. Because HHS' calculation will include premium and the maximum out-of-pocket amount (MOOP) and because of the structure of the actuarial value (AV) calculator, plans with lower cost-sharing on services generally must have higher MOOPs and deductible amounts in order to meet AV. By looking only at the MOOP, a consumer could be moved from a bronze plan with generous first dollar coverage into a health savings account (HSA) eligible bronze plan, with almost all benefits subject to deductible, or from a bronze plan with copays for all office visits to a silver plan with coinsurance for office visits. In general, the proposed changes to the reenrollment hierarchy would harm consumers subject to these types of plan changes.

Oregon supports helping enrollees choose the most beneficial plans but does not believe that moving enrollees into a new plan when their current plan continues to exist is in the best interest of consumers. There are a multitude of reasons why a consumer might choose a particular plan, and it is impossible to account for all of them with a hierarchy. As Oregon has done for the past several years, Oregon continues to urge HHS to revamp the plan display at HealthCare.gov to better educate consumers about the differences among plans. Doing so would be particularly helpful for consumers if HealthCare.gov highlighted which services are not subject to deductible and illustrated why copays are generally more beneficial than coinsurance on commonly used services like office visits.

7. Special Enrollment Periods (§ 155.420)

a. Use of special enrollment periods by enrollees

Oregon supports the proposed technical corrections to § 155.420(a)(4)(ii)(A) and (B) to align the text with § 155.420(d)(6)(i) and (ii). The proposed revisions would clarify that only one person in a tax household applying for coverage or financial assistance through an exchange must qualify for a special enrollment period under paragraphs (d)(6)(i) and (ii) in order for the entire household to qualify for the special enrollment period.

b. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

Oregon supports the proposed amendments to the coverage effective date rules to permit exchanges the option to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC. Oregon encourages HHS to implement some guardrails to the timeframe in which a consumer has to request these effective dates in cases of retro-active enrollment to prevent any adverse selection. An example of such could be that the consumer must request any retroactive coverage due to mid-month termination no later than 60 days after the date of termination.

c. Special rule for loss of Medicaid or CHIP coverage (§ 155.420(c))

Oregon supports the proposed rule to mitigate coverage gaps when consumers lose Medicaid or CHIP coverage and to allow for a more seamless transition into exchange coverage, the proposed a new special rule under § 155.420(c)(6) to provide more time for consumers who lose Medicaid or CHIP coverage that is considered MEC as described in § 155.420(d)(1)(i) to report their loss of coverage and enroll in exchange coverage. The proposed regulation would

align the special enrollment period window following loss of Medicaid or CHIP with the reconsideration period available under 42 CFR 435.916(a).

d. Plan Display Error Special Enrollment Periods (§ 155.420(d))

Oregon agrees that cost-sharing should be added to the list of plan display errors. In addition, Oregon urges HHS to add HealthCare.gov provider search errors to the list. Consumers who see inaccurate provider information on HealthCare.gov have no recourse if they enroll in a plan that does not actually cover their provider. When the error occurs in the insurance carrier's directory, Oregon requires the carrier to honor that mistake. As HHS cannot require the carrier to honor HHS's mistake, consumers should be given a special enrollment period (SEP) so that they can enroll in a plan that does cover their provider.

Oregon also supports HHS's proposal to provide an SEP to consumers whose providers leave the network mid-year and suggest extending this SEP when a provider group, clinic, or health system leaves a carrier's network. Carriers often arrange to honor claims for consumers undergoing treatment with the out-of-network providers but having the ability to change plans would also be beneficial to consumers.

8. Termination of Exchange Enrollment or Coverage (§ 155.430)

a. Prohibition of Mid-Plan Year Coverage Termination for Dependent Children who Reach the Maximum Age

Oregon supports the proposal to explicitly prohibit QHP issuers participating in exchanges on the federal platform from terminating coverage of dependent children before the end of the coverage year because the child has reached age 26 (or, if greater, the maximum age at which issuers are required to make coverage available under state law). Oregon agrees that the termination of dependent coverage due to age should align with the end of the plan year, the eligibility determination, and the payment of APTCs.

b. There is no 8.b. To reduce confusion and make commenting easier in future NBPPs, Oregon requests that HHS not assign a lettered subsection to numbered single sections. Alternatively, Oregon requests that HHS reserve the second lettered subsection of a numbered section when only one lettered subsection contains content. For example, because there is no subsection b, section 4 should have been written as, "4. Eligibility Standards (§ 155.305) – Failure to File and Reconcile Process (§ 155.305(f)(4))," or HHS should have added a subsection b. as follows: "b. Reserved."

9. General Eligibility Appeals Requirements (§ 155.505)

Oregon supports the proposed changes.

10. Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges (§§ 155.1500 through 155.1515)

a. Purpose and scope (§ 155.1500)

b. Definitions (§ 155.1505)

- c. Data submission (§ 155.1510)
- d. Pre-testing and assessment procedures (§ 155.1515)

Oregon is opposed to the proposed establishment of new subpart P under 45 CFR part 155. The new subpart establishes the IPPTA, an improper payment measurement program of APTCs, that will include state exchanges. The proposed IPPTA would prepare state exchanges for the planned measurement of improper payments of APTCs, would test processes and procedures that support HHS' review of determinations of APTCs made by state exchanges, and would provide a mechanism for HHS and state exchanges to share information that would aid in developing an efficient measurement process. Adding an additional program with required reporting is an unnecessary burden is redundant to the state-based marketplace annual reporting tool (SMART). As opposed to creating a new program with required reporting, Oregon would be much more supportive of creating a new section for the current SMART to include additional data requested by HHS.

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

1. FFE and SBE-FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

- a. FFE User Fee Rates for the 2024 Benefit Year
- b. SBE-FP User Fee Rates for the 2024 Benefit Year

Oregon continues to request greater clarity and transparency surrounding the cost of the federal platform, call center, other programs associated with running the exchange, individual state usage of these federal resources, allocated costs, and how individual state user fees compare to their allocated costs. Oregon also continues to oppose continued use of a premium-based assessment.

As Oregon has commented for the past several years, there is little, if any, transparency around the costs associated with providing FFE services and infrastructure or how these costs are allocated to the states. Without transparency, it is difficult, if not impossible, to determine what the user fee should be and to provide informed and thoughtful comment.

Oregon again urges HHS to be transparent and specific with the calculation of the user fee by enumerating the actual costs of providing FFE services and infrastructure to each state. Not only are these data necessary for user-fee purposes, they are also necessary to facilitate SBE-FP states' 1332 waiver applications for waiver of the exchange requirements and to determine the budget neutrality of technical coordination, as some of these costs could be payable by a state outside of a waiver, while others may be subject to the budget neutrality guardrail.

Finally, Oregon continues to press HHS to fund the FFE via a per-member per-month fixed dollar charge on the actual number of individuals from each state who use FFE services. Because HHS's FFE costs are largely fixed, the FFE's funding should be based on fixed revenue rather than revenue that fluctuates based on premium increases or decreases. This is especially important because, as indicated in this NBPP, premiums generally increase at the rate of medical inflation, which is typically much higher than the inflationary rate applicable to infrastructure and nonmedical services. Although enrollment is not fixed, it has been relatively consistent for at least the past three years and is more reliably predictable than premiums. Accordingly, HHS should impose a flat per-member per-month assessment to cover its costs.

2. Publication of the 2024 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130)

Oregon has no comment on this proposal.

3. Standardized Plan Options (§ 156.201)

Oregon supports allowing states that currently require carriers to offer standard plans to continue to use their own standard plan designs, rather than requiring them to adopt CMS's plan designs.

4. Non-Standardized Plan Option Limits (§ 156.202)

Limiting plans by metal tier

Oregon adamantly opposes the proposal to limit non-standard QHPs in SBE-FP states. While HHS is the authority in the partnership and full FFE states, Oregon reserves its authority to conduct all plan management activities as described in sections 4.1(a) and 4.1(b) of the Blueprint for Approval of State-Based Health Insurance Exchanges¹. Oregon has a proven track record of monitoring carriers and plans and using the tools at its disposal to ensure Oregonians are offered a range of plan options that suit their families. The state has a large network of agents and navigators, and OHIM encourages consumers to access free, local help when applying for coverage. OHIM and Oregon's insurance regulator, the Division of Financial Regulation (DFR), have a strong working relationship that has existed since the creation of Oregon's exchange. Together, these entities set plan requirements, monitor carriers for compliance with state and federal law, and design the Oregon Standard Plans.

Carriers have naturally decreased their plan offerings as the market has matured and consumer preferences have become apparent. Two of OHIM's six carriers already meet HHS's proposed limitation. Of the other four carriers, the highest number of non-standard plans offered by one carrier at one metal tier in one network is four silver plans. Oregon does not believe this kind of choice creates decision paralysis or hinders the ability of consumers to engage in plan selection.

While Oregon understands that HHS wishes to prevent choice overload, under the proposal, a significant number of plans will still be available in markets with several insurance carriers. A better solution is to improve HHS's choice architecture. Without good choice architecture, even a large set of standard plans becomes unwieldy. Oregon has repeatedly urged HHS to provide better functionality for consumers shopping for coverage and continues to do so.

HHS suggests that limiting plans is a better option than improving HealthCare.gov, citing the number of consumers who shop via other avenues, such as federal marketplace call center representatives, agents, assisters, and enhanced direct enrollment sites. It's quite likely that consumers seek alternative shopping methods because of the relatively poor shopping experience provided by HealthCare.gov. If HHS improves the consumer experience, the number of consumers using alternative methods will most certainly decrease. Oregon

¹ Centers for Medicare and Medicaid Services. *Blueprint for Approval of State-Based Health Insurance Exchanges*. <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CMS-Blueprint-Application.pdf>

respectfully suggests that the more consumers who shop through HealthCare.gov rather than through the call center, the better. Unfortunately, over the years, we have received many consumer complaints about the call center – the majority revolve around the receipt of incorrect information from the representatives.

The role of agents, assisters, and enhanced direct enrollment services is to direct consumers to the plans most suited for them by eliminating less advantageous plan choices. If those entities are well-trained and performing their duties correctly, the number of plan offerings should not be a barrier to enrollment.

Contrary to HHS's assertion otherwise, SBEs are **not** in a better position to understand the needs of their consumers better than SBE-FPs. OHIM and DFR each have staff members who have worked together on Oregon qualified health plans for over a decade. Oregon has a well-established process for collecting consumer complaints, requesting community feedback, and adjusting plan requirements to best serve Oregonians. Oregon carriers have a long history of covering Oregonians in multiple markets – of Oregon's six health insurance carriers, three have their headquarters here, and the other three have very large regional offices in the state. SBEs have solicited OHIM's feedback on various exchange operations, including creation of standard plans, use of the System for Electronic Rate and Form Filing (SERFF), and calculation of APTCs for standalone plan displays when pediatric dental is not embedded. CMS, itself, has asked for OHIM's participation on the Quality Ratings System/Quality Improvement Strategy Technical Advisory Panel, and Oregon is the only HealthCare.gov state on the Standardized Plan Workgroup.

Additionally, to say that SBE states have worked harder to implement innovative policies is factually incorrect. The amount of plan management work is not decreased for an SBE-FP, which is responsible for the same plan management responsibilities as an SBE. HHS's statement ignores the significant amount of work the state has done to fit into the rigid structure HHS sets for the FFE states while also working creatively to offer innovative plan options to Oregonians. For example, to combat the continued deficiencies of the HealthCare.gov plan display, OHIM has provided Oregonians with a standalone plan display since October of 2018. Oregon's plan display receives over 30,000 unique visitors each open enrollment, with visitors averaging five minutes on the site before moving to HealthCare.gov for enrollment. The plan display provides consumers with information omitted on HealthCare.gov, including cost-sharing for imaging (MRI, CT, and PET scans), prenatal and postnatal office visits, and physical therapy office visits. The provider search includes a cleaned hospital data set, which increases accuracy when consumers search for coverage that includes a particular hospital system. The state's display also includes filtering functionality that does not require users to go to a second screen, allows users to filter by more than one insurance carrier, and allows users to view more than three plans at one time. Finally, OHIM's display includes a formulary search that shows consumers which plans cover their medication and at what cost-sharing.

OHIM has used its standalone plan display to quickly inform consumers of changes during the COVID-19 pandemic, such as changes to eligibility for consumers receiving unemployment assistance. Consumers who used the site were routed directly to Medicaid when eligible, saving them the effort of completing a HealthCare.gov application. The plan display includes an employer-sponsored coverage affordability calculator. Language OHIM created was adopted by other states for use in their plan displays. Oregon will use the state standalone plan display to aid consumers leaving Medicaid at the end of the continuous coverage requirement.

HHS states that exempting SBE-FPs from the plan limit requirement “would create a substantial financial and operational burden.” Oregon disagrees that maintaining the current system functionality is a significant burden. The system changes to implement the plan limits are new functionality for which Oregon did not ask and to which HHS knows Oregon is opposed and has been opposed for years. Changing the current system is what creates the burden. HHS should include an exemption for Oregon in both the budgeting and operational planning for the new functionality. It is unfair to suggest that Oregon’s request for exemption creates a burden, rather than acknowledging that HHS has decided to move forward without reasonably accommodating for the legitimate concerns Oregon has raised for several years.

Oregon is concerned by the market implications of artificially limiting plan offerings, particularly in the silver tier. There is a significant range in silver plan premiums. Removing silver plans may cause large shifts in tax credits. If lower priced plans in each tier are removed, consumers who do not receive tax credits may not be able to afford the more expensive plans that remain. Implementing this policy will require Oregon to instruct carriers on which plans to remove to prevent market-wide issues. Though Oregon has a highly regulated market, it has created a good balance between prescribing coverage options and allowing carriers file the offerings they believe consumers want to purchase. Enforcing plan limits will likely strain the good relationships that Oregon has worked hard to create with its carriers.

If HHS imposes plan limits despite Oregon’s opposition, HHS should do the following:

- Exempt HSA-eligible plans from the bronze non-standard plan count – HSA-eligible plans are not a value for the majority of consumers, but there are higher-income consumers savvy enough to benefit from an HSA-eligible plan. These enrollees are a small but vocal population, and it is important to continue to provide them with HSA-eligible plans. Notwithstanding, Oregon does not recommend continuing those offerings at the expense of more valuable plans that offer pre-deductible coverage. Allowing carriers to offer two non-standard bronze plans in addition to an HSA-eligible bronze and the standard bronze would offer more protection to consumers who may not understand the higher cost-sharing on HSA-eligible plans. This would also ensure that consumers who do not receive tax credits have enough choice to entice them to remain in the market.
- Set plan limits by network, not service area – In the proposed rule, there is an example of a carrier offering two non-standard HMO plans in a service area covering part of the state and two other non-standard HMO plans in a statewide service area, resulting in four HMO plans in the overlapping service areas. The proposed rule would limit the carrier to one non-standard plan in each service area or would require the carrier to remove non-standard coverage from one of the service areas. Oregon assumes the carrier in the example is offering two separate networks and would then have to remove plans from one or both networks. This is not useful for many consumers. There are consumers who are well-served by smaller, less expensive networks, and there are consumers who are willing to pay more for a larger of pool of providers and facilities. Both groups deserve the same access to plan choice as consumers enrolled with carriers that only offer one network. Oregon consumers are used to multiple networks from one carrier and are able to distinguish the networks by plan name, as OHIM carriers include the network name in the plan name.

Later in the proposed rule, HHS suggests using network ID to separate these offerings, allowing two non-standard offerings per network ID. This is a more useful approach and would allow consumers to remain in their current networks.

Limiting plans by meaningful difference standard

Oregon supports HHS's suggestion to revise the meaningful difference standard, and to implement that as a way to reduce plan offerings. However, Oregon seeks clarity on whether carriers' plans would be required to meet the standard when compared to standard plans, or only when the non-standard plans are compared to each other.

Oregon suggests a deductible difference of \$500 because a \$1,000 deductible may be difficult to implement and maintain, given the continuous struggle of meeting actuarial value. Oregon also suggests that HHS consider a standard that would disregard deductible differences in favor of benefit differences, such as offering dental (pediatric and/or adult), adult vision, or a specific number of office visits at no cost-sharing.

5. QHP Rate and Benefit Information (§ 156.210)

- a. Age on Effective Date for SADPs
- b. Guaranteed Rates for SADPs

Oregon supports requiring issuers of standalone dental plans (SADPs) to use an enrollee's age on effective date as the sole method for calculating age. Oregon also supports the proposal to require all issuers of SADPs to provide guaranteed rates. These policies align with consumer expectations and are consistent with current industry practices in Oregon.

Oregon requests clarity on whether the changes to the rating requirements apply in small group SADPs as well. The state does not have authority to review dental rates for small group carriers. The carriers that participate in the Small Business Health Options Program (SHOP) file rate data templates, but they are not required to put their actual rates in the templates. Oregon SHOP carriers all offer individual plans as well, so they do file correct rating business rules templates.

Because OHIM is required to do so, OHIM certifies a very small number of off-exchange-only, small-group SADPs, offered by carriers that do not offer any coverage on-exchange. These carriers are not required to file rating business rules templates or rate data templates. Because Oregon does not have authority to review their rates and OHIM does not contract with them or have any authority over them, Oregon is unable to enforce this proposed certification requirement. If plans cannot be certified without meeting this requirement, HHS should certify the off-exchange-only plans.

6. Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

Oregon supports the proposal to better manage plan marketing names. However, Oregon would caution against allowing or requiring carriers to include lengthy benefit descriptions. The plan name should identify the plan and differentiate it from other plans, but it is not the

appropriate location for consumers to compare benefit information. Ideally, a consumer should easily be able to remember the name of their plan.

To that end, Oregon suggests the following naming parameters:

- Allow carriers to include the deductible amount without labeling it as such. Oregon carriers have included deductible amounts in their plan names for the last ten plan years, and it has not been a source of consumer confusion. Adding the word “deductible” is unnecessary and makes the plan name longer and harder to remember. In addition, as Oregon requires its plans to cover a significant number of benefits ahead of deductible, deductible should not be overemphasized when many enrollees may pay little or nothing toward it.
- Exempt plan name changes for plans that have been offered under the same name, with the exception of changes to cost-sharing amounts, for three or more years. Many plans have been offered for five or more years under the same name, and it would be very confusing for enrollees to see a new plan name when the plan, itself, has not changed.
- Require carriers that offer more than one network to include the network name in the plan name. This is helpful for consumers, assisters, and providers.
- Create a required naming convention for standard plans that includes “standard,” in the plan name, e.g., “Cascade [network] Standard Gold [tier] 500 [deductible].” This makes standard plans obvious during shopping. It is also easier for carriers when the standard plan names are prescribed.
- Prohibit carriers from including the company name in the plan name because the carrier’s name is displayed along with the plan name. Thus, including the company name in the plan name is duplicative and increases the length of the plan name.
- Impose a character limit to prevent carriers from creating overly long and complicated plan names.

7. Plans That Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

Oregon supports applying the federal standards for network adequacy and essential community provider to all plans sold on exchanges. Oregon has its own network adequacy law (ORS 743B.505) that meets or exceeds the requirements of 45 CFR § 156.230 and 156.235. Oregon’s law already applies to all plans sold in the state, regardless of whether a particular plan explicitly uses a network or not.

8. Essential Community Providers (§ 156.235)

Oregon supports the proposal to establish two new ECP categories and increase the threshold for federally qualified health centers and family planning providers.

9. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

a. Establishing a Timeliness Standard for Notices of Payment Delinquency

Oregon supports establishing a timeliness standard when a QHP issuer sends a notice of payment delinquency. Requiring these notices to be sent “promptly and without undue delay” will help ensure these notices are sent in a timely manner and thus are received by enrollees while they still have time to act on the delinquency. To provide further certainty for issuers and enrollees, Oregon encourages HHS to also specify the exact number of days an insurer has to send these notices.

Under ORS 743B.323, Oregon requires insurers to send a separate notice of nonpayment to an enrollee at least 10 days before the end of any applicable grace period (including the three-month APTC grace period). Importantly, this section prohibits Oregon insurers from terminating coverage until and unless the separate notice has been sent and the corresponding time period has expired, even if the enrollee’s payment grace period has already expired. Imposing these additional timing requirements on the notices of nonpayment has created a strong incentive for insurers to send these notices as early as possible.

b. There is no 9.b. To reduce confusion and make commenting easier in future NBPPs, Oregon requests that HHS not assign a lettered subsection to numbered single sections. Alternatively, Oregon requests that HHS reserve the second lettered subsection of a numbered section when only one lettered subsection contains content. For example, because there is no subsection b, section 4 should have been written as, “4. Eligibility Standards (§ 155.305) – Failure to File and Reconcile Process (§ 155.305(f)(4)),” or HHS should have added a subsection b as follows: “b. Reserved.”

10. Final deadline for reporting enrollment and payment inaccuracies discovered after the initial 90-day reporting window (§ 156.1210(c))

Oregon generally supports the proposal to amend § 156.1210(c) to remove the alternate filing deadline allowing an issuer to describe all data inaccuracies identified in a payment and collection report by the date HHS notifies issuers that the HHS audit process with respect to the plan year to which such inaccuracy relates has been completed, in order for these data inaccuracies to be eligible for resolution. However, Oregon opposes the language that would permit waiver of any user fees owed to an SBE-FP if inaccuracies are discovered after the deadline. There is no blanket justification for user fees owed to an SBE-FP not to be paid regardless of when inaccuracies are discovered. At most, whether such fees are repaid should be a question for the SBE-FP determined on a case-by-case basis. Moreover, at least in Oregon, user fees are determined by state law, and nothing in state statute or rule would remove the obligation to pay such fees based on the deadline referenced in the rule. In this case, HHS does not have the authority to waive fees that are mandated by state statute for services provided by a state agency.

11. Administrative Appeals (§ 156.1220)

Oregon supports the proposed changes.

The department and the authority appreciate the opportunity to comment. If HHS has questions about these comments, please contact either of us at the email addresses below.

Sincerely,



Andrew R. Stolfi
Director
Department of Consumer and Business Services
andrew.r.stolfi@dcbs.oregon.gov



Chiqui Flowers
Director
Oregon Health Insurance Marketplace
Division of Health Policy and Analytics
Oregon Health Authority
chiqui.l.flowers@dhsosha.state.or.us



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 principles¹ 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.

<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 the 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 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 afieid 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,

Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
CancerCare
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
National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
The Mended Hearts, Inc.

January 30th, 2023

VIA ELECTRONIC FILING – <http://www.regulations.gov>

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

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Attention: CMS-9899-P, Mail Stop C4-26-05
Baltimore, MD 21244-1850

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024; RIN: 0938-AU97, Docket ID: CMS-9899-P

Dear Secretary Becerra and Administrator Brooks-LaSure:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to submit comments on the Notice of Benefit and Payment Parameters (NBPP) for plan year 2024 proposed rule published by the U.S. Department of Health and Human Services (HHS).¹ PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier and more productive lives. Since 2000, PhRMA member companies have invested more than \$1.1 trillion in the search for new treatments and cures, including \$102.3 billion in 2021 alone.

Comprehensive, affordable, and accessible prescription drug coverage is important to preventing, treating, and curing acute and chronic medical conditions, as well as improving quality of life and reducing spending on other health care services.² Recent research shows that today, many Americans face affordability challenges in accessing the brand medicines they need in part because of health plans' increased use of benefit designs utilizing high deductibles and coinsurance. Across the seven therapeutic areas included in an analysis of IQVIA data, patients with deductibles and/or coinsurance paid as much as 30 times more out of pocket annually for

¹ 87 Fed. Reg. 78206 (Dec. 21, 2022).

² Congressional Budget Office. Offsetting effects of prescription drug use on Medicare's spending for medical services. 2012. https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/MedicalOffsets_One-col.pdf.

brand medicines than patients with only copays.³ The increasing use of deductibles and coinsurance by health plans disproportionately burdens patients with chronic conditions who are prescribed medicines, including some of the most disadvantaged in the health system.⁴ For example, research from Harvard University shows that reduced cost sharing for cardiovascular medicines increased adherence and had a greater impact on reducing the risk of vascular events and medical costs among nonwhite patients.⁵

We support many of the proposals in the proposed 2024 NBPP that would help improve the affordability of and access to health care, particularly those that could improve health equity. However, more needs to be done to counteract current trends in benefit design and eroding prescription drug coverage that is shifting more and more costs for medicines to patients and exacerbating health disparities. We stand ready to work with this Administration toward this important goal.

PhRMA has the following specific comments, which we discuss in greater detail below:

- **Reduce enrollee cost-sharing.** To counteract rising out-of-pocket expenses for individuals and families, HHS should act to prohibit schemes by insurers, plans, pharmacy benefit managers (PBMs) and third parties that penalize patients who access manufacturer cost-sharing assistance by not counting the full amount of that support toward the patient's deductible or out-of-pocket maximum. At a minimum, HHS should extend protections across the commercial health insurance market to apply to all non-grandfathered group health plans so that those plans cannot designate certain drugs as non-essential health benefits and charge excessive cost sharing for those drugs.
- **Prohibit coverage discrimination for preexisting conditions.** An important consumer protection under the Affordable Care Act (ACA) is the prohibition on imposing any preexisting condition exclusion.⁶ A type of cherry-picking strategy that exists today is excluding coverage for some or all specialty medication to avoid providing coverage to individuals living with preexisting conditions or higher health costs. This is particularly alarming given the overall erosion of health insurance coverage occurring in the commercial market either by shifting costs to patients with higher cost sharing obligations to access their medication or shifting access itself onto

³ PhRMA. Faced with high cost sharing for brand medicines, commercially insured patients with chronic conditions increasingly use manufacturer cost-sharing assistance. July 2020.
[https://phrma.org/media/Project/PhRMA/PhRMA-Org/PhRMAOrg/PDF/D-F/Faced-with-High-Cost sharing-for-Brand-Medicines.pdf](https://phrma.org/media/Project/PhRMA/PhRMA-Org/PhRMAOrg/PDF/D-F/Faced-with-High-Cost%20sharing-for-Brand-Medicines.pdf).

⁴ Megan B. Cole, PhD, MPH; Jacqueline E. Ellison, MPH; Amal N. Trivedi, MD, MPH; "Association Between High-Deductible Health Plans and Disparities in Access to Care Among Cancer Survivors," JAMA, June 2020.

⁵ Choudhry, NK., Bykov, K., Shrank, WH., et al. Eliminating medication copayments reduces disparities in cardiovascular care. Health Affairs 2014 33:5, 863-870.
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0654>.

⁶ Public Health Service Act §§ 2702-2705, 42 U.S.C. §§ 300gg-1- to -4.

manufacturer assistance or independent charitable assistance. These types of patient assistance programs are designed to support and assist patients who are truly unable to afford their medication because they are uninsured or have insurance coverage, but are exposed to high financial risk because they cannot afford their out-of-pocket costs, i.e., the underinsured. HHS should prohibit the development or administration of benefit design or coverage in a manner that takes into account third-party financial assistance or charitable foundations.

- **Maintain prescription drug tiering and pre-deductible coverage in standardized plans.** PhRMA supports maintaining four prescription drug tiers as a patient-friendly structure that improves peoples' ability to understand, compare and choose the coverage that is right for them. We also support the removal of non-expanded bronze plans from the standardized plan rubric, due to their inability to offer pre-deductible coverage.
- **Limit non-standardized plans.** Establishing reasonable limits on the number of plans in the Exchange could help patients shop and decipher important differences between offerings, such as formularies and cost-sharing obligations, before plan selection to avoid suboptimal selections.
- **Require accuracy in plan marketing.** Plan names – like all other advertised plan elements – should be required to be accurate.
- **Enforce and extend network adequacy and essential community provider requirements.** We support enforcement of the network adequacy rules, including time and distance standards, and encourage HHS to consider enrollees' access to pharmacies, which is sometimes problematic in rural areas and by racial and ethnic composition. Expanding the required contracting and types of essential community providers is also important.
- **Supporting new and continuous enrollment.** PhRMA appreciates HHS's proposals that make it easier for consumers to enroll and stay enrolled in the most appropriate coverage, including the proposed change to plan hierarchies, relying on applicant income attestations, and modifying special enrollment periods to reduce gaps in and loss of coverage.
- **Ensuring accuracy in risk adjustment.** We encourage HHS to evaluate the risk adjustment model continually to ensure it fully captures the cost of the current standard of care for conditions in the model.

Prescription Drug Access and Affordability for Commercially-Insured Patients

Annual Limit on Cost Sharing (§ 156.130 and CCIIO Guidance⁷)

⁷ Center for Consumer Information and Insurance Oversight (CCIIO). Letter. Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year. December 12, 2022. <https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf>.

In § 156.130 and its referenced guidance, CMS establishes the annual limits on cost sharing at a 4 percent increase over 2023 levels. PhRMA is concerned about the escalating out-of-pocket responsibilities that patients shoulder and recommends two commonsense policies to help relieve families of some of these costs: 1) restricting accumulator adjustment programs, copay maximizers, and similar programs targeted at co-opting manufacturer cost-sharing assistance, and 2) requiring that all covered drugs be considered essential health benefits (EHB) in non-grandfathered group health plans (as is already the case in individual and small group health insurance coverage).

Accumulator adjustment programs, copay maximizers, and any other scheme by which health plans, PBMs, or third parties profit from copay assistance, undermine the intended impact of this type of assistance, which helps eligible patients afford their out-of-pocket costs at the pharmacy counter and can significantly improve patient adherence to medicines. In 2019, the use of these cost-sharing assistance programs reduced patients' likelihood of abandoning their brand medicines at the pharmacy by an estimated 82 percent.⁸ Administration action is needed on accumulator adjustment programs and copay maximizers to ensure that funds are not diverted from cost-sharing assistance and patients for the enrichment of insurers, plans, PBMs or other third parties.

Analysts report that accumulator adjustment programs and copay maximizers – programs operated by entities outside the control of manufacturers– have become more commonplace in the commercial market.⁹ PBMs and plans have been opaque about when they operate an accumulator adjustment program and how it will impact patients.¹⁰ Among health insurance Exchange plans, 42 percent did not disclose use of an accumulator adjustment program in materials made available prior to plan enrollment.¹¹

Making it more difficult for patients to satisfy their cost-sharing limits by capturing the benefits provided by manufacturer cost-sharing assistance programs is particularly harmful to those who require multiple medicines. For those individuals, disregarding amounts paid with help from a manufacturer cost-sharing assistance program means they will pay a higher share of the cost for other health care services or medicines that are not covered by such a program, multiplying the potential for non-adherence.

⁸ Only 5 percent of patients abandoned newly prescribed brand medicines when using cost-sharing assistance. Analysis suggests that abandonment would have been 28 percent if not for this cost-sharing assistance. IQVIA analysis of LAAD dataset for PhRMA. February 2021.

⁹ Fein AJ. "The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers." Drug Channels Institute. March 2022.

¹⁰ Fein AJ. "Hidden policies: the search for copay accumulator policies in Florida qualified health plans." Drug Channels. June 2018. <https://www.drugchannels.net/2018/06/hidden-policies-search-for-copay.html>.

¹¹ The AIDS Institute. "Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness: Copay Accumulator Adjustment Policies In 2022." January 2022. https://aidsinstitute.net/documents/final_TAI_2022-Report-Update_020122.pdf.

As use of accumulator adjustment programs, copay maximizers, and other such schemes grows, their potential impact on certain patients – based solely on a patient’s medical condition or need for a specific medicine – is concerning and could run afoul of nondiscrimination requirements.¹² As HHS recognizes, imposing higher cost-sharing can be an indicator of discriminatory plan design.¹³ Benefit designs with higher cost sharing can discourage individuals living with disabilities and chronic conditions from enrolling into health plans with higher cost-sharing obligations as well as hinder patients from accessing their medication under their health insurance coverage because of the associated higher out-of-pocket costs. Prohibiting programs and practices that raise cost-sharing for select enrollees is a key protection, particularly for those living with chronic conditions who bear the brunt of paying higher out-of-pocket costs to access their life-saving medication.

Commercially-insured patients are also harmed when third parties siphon funds from manufacturer patient assistance programs or independent charitable assistance that are intended for the uninsured or underinsured.¹⁴ For example, alternative funding programs are another potentially discriminatory strategy to take advantage of manufacturer patient assistance programs or independent charitable assistance programs that provide free medications to eligible uninsured and underinsured patients. In these programs, claims for branded specialty drugs are automatically denied by the PBM and patients are referred to an alternative funding vendor that facilitates enrollment into manufacturer patient assistance programs or other condition-specific charities or foundations designed to assist eligible uninsured or underinsured patients.¹⁵

Alternative funding programs allow commercially insured patients, who otherwise may not be eligible for the manufacturer charities or foundations, to access funds intended for uninsured or underinsured patients. These programs target specialty drugs and thus disproportionately affect individuals living with disabling chronic and rare conditions who need these life-saving specialty medications. Individuals living with chronic conditions must undergo additional processes after their claim is denied – without any discernable clinical justification – which delays their therapy, interferes with the clinical decision making of their provider and potentially puts them at risk of poorer health outcomes.

¹² For more detail, see PhRMA’s comment letter on the 2023 NBPP: <https://www.phrma.org/policy-issues/Access/Insurance-Coverage/PhRMA-Comments-on-the-2023-Notice-of-Benefit-and-Payment-Parameters-Proposed-Rule>

¹³ 87 Fed. Reg. 47824 at 47869

¹⁴ “Underinsured” refers to those individuals and families that have health coverage, but are still exposed to high financial risk because they cannot afford their out-of-pocket costs. See Lavarreda, S. “Underinsurance in the United States: An Interaction of Costs to Consumers, Benefit Design, and Access to Care. *Ann. Rev. Public Health.* (Vol. 32, pg. 471-82). <https://www.annualreviews.org/doi/pdf/10.1146/annurev.publhealth.012809.103655>.

¹⁵ See RxBenefits, Understanding Funding for Specialty Medications, <https://www.rxbenefits.com/ebooks/understanding-alternative-funding-for-specialty/> (last accessed Aug. 21, 2022); Industry Experts Question Alternative Funding Companies That Carve Out Some Specialty Drugs, ‘Abuse Charities,’ AISHealth, Sept. 1, 2022, <https://www.mmitnetwork.com/aishealth/spotlight-on-market-access/industry-experts-question-alternative-funding-companies-that-carve-out-some-specialty-drugs-abuse-charities/> (last accessed Sept. 26, 2022).

Patients can lose access to or unknowingly exhaust patient assistance programs that are drained by these third-party schemes to shift coverage onto resources intended for disadvantaged populations. Depleting patient assistance programs disproportionately disadvantages individuals and families living with serious or chronic conditions who require this help. Plans and third parties should not be permitted to game these programs and deplete their impact on individuals and families who are uninsured or qualify for needed financial assistance. We urge HHS to make the following regulatory changes.

Restrict Accumulator Adjustment Programs

PhRMA remains deeply concerned about HHS's arbitrary reversal in the 2021 NBPP final rule to permit group health plans and health insurance issuers to use accumulator adjustment programs without limitation,¹⁶ which has likely resulted in higher out-of-pocket prescription drug costs for millions of patients.¹⁷ This policy allows plans and issuers to exclude the value of manufacturer cost-sharing assistance from accruing toward the statutorily required annual limitation on cost sharing. Historically, such cost-sharing assistance has counted toward the annual limitation on cost sharing under the ACA, which helps protect enrollee access to medically-necessary treatment options. The current policy undermines this important patient protection under the ACA that provides patients and families with greater predictability and certainty about their maximum out-of-pocket exposure on an annual basis.

Further, the current policy compromises patients' ability to adhere to prescribed medicines at a moment when insurance coverage for medicines continues to erode. It puts patient health and financial security in danger, and it runs directly counter to the important policy goals of lowering patient out-of-pocket costs for prescription drugs and taking steps to eliminate disparities in health care access and outcomes. One study found that, on average, cost-sharing assistance helped patients taking HIV or oncology medicines with more than \$1,600 toward their out-of-pocket costs in 2019 and helped patients taking multiple sclerosis (MS) medicines with more than \$2,200 toward their out-of-pocket costs.¹⁸ This is especially concerning for patients living with rare conditions, who often have fewer therapeutic alternatives and need certain medications in order to live. Despite HHS's assertions in the 2021 NBPP Final Rule that "we believe the impact to consumers will be minimal if issuers choose to continue their current behavior"¹⁹ a

¹⁶ HHS Notice of Benefit and Payment Parameters for 2021. 85 Fed. Reg. at 29261 (codified at 45 C.F.R. § 156.130(h))

¹⁷ We have discussed our opposition to accumulator adjustment programs at length in both our comment letter on the 2021 NBPP proposed rule and our comment letter on the Medicaid Value-Based Purchasing proposed rule (85 Fed. Reg. 37286 (June 19, 2020)). When a health plan uses an accumulator adjustment program, it jeopardizes patients' ability to access needed medications, particularly when there may be no alternative options. This disruption can reduce adherence and increase abandonment, exacerbating underlying health conditions and leading to worse outcomes. Accumulator adjustment programs hurt enrollees, and HHS should not permit or encourage them.

¹⁸ PhRMA. Faced with high cost sharing for brand medicines, commercially insured patients with chronic conditions increasingly use manufacturer cost-sharing assistance. July 2020. <https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMAOrg/PDF/D-F/Faced-with-High-Cost-sharing-for-Brand-Medicines.pdf>.

¹⁹ 85 Fed. Reg. at 29232 (May 14, 2020).

national survey conducted by the National Hemophilia Foundation found that 72 percent of survey respondents believed that many patients would no longer be able to afford their medications if cost-sharing assistance was not permitted to be applied to annual out-of-pocket limits.²⁰

When accumulator adjustment programs are implemented by health plans and PBMs, they can substantially increase patients' out-of-pocket costs, increasing financial burden and health risk, especially for those with serious rare and chronic illnesses. Several states have taken steps to ban or limit use of accumulator adjustment programs, however, a federal accumulator prohibition is needed to assist all commercially insured patients.²¹ HHS itself acknowledges "situations when a patient has been subject to significant out-of-pocket costs because the patient has not progressed through the deductible phase of the health plan" due to accumulator adjustment programs not applying the value of the manufacturer-sponsored assistance to the patient's deductible.²² Further, HHS notes that "when this happens, the patient may be forced to stop taking the drug, switch to an alternative offered by the plan, or pay the full bill for the non-formulary drug, none of which are patient-friendly, especially for those patients with rare and life threatening conditions."²³ Thus, accumulator adjustment programs can undermine medication adherence, which can lead to negative health outcomes for patients and increase overall health care costs.²⁴ Accordingly, we urge HHS to protect patients by reinstating the requirement from the 2020 NBPP final rule that plans must count manufacturer cost-sharing assistance toward the annual limitation on cost sharing for drugs that do not have a medically-appropriate generic equivalent available.²⁵

Extend EHB Cost-Sharing Protections to All Non-Grandfathered Group Health Plans

Health plans and PBMs are using "copay maximizer programs," which subject certain patients to atypically high cost sharing based on their medical need for a medicine for which manufacturer

²⁰ National Hemophilia Foundation. Americans Believe Government Should Require Copay Assistance Be Applied to Out-of-pocket Costs. October 15, 2020. <https://www.hemophilia.org/news/americans-believe-government-should-require-copayassistance-be-applied-to-out-of-pocket-costs>

²¹ To date, 16 states have banned accumulator adjustment programs: AR, AZ, CT, DE, GA, IL, KY, LA, ME, NC, NY, OK, TN, VA, WA, WV. <https://avalere.com/insights/state-copay-accumulator-bans-impact-11-of-us-commercial-lives>

²² Final Rule: Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability (TPL) Requirements (CMS-2482-F) from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. <https://www.federalregister.gov/documents/2020/12/31/2020-28567/medicaid-program-establishing-minimum-standards-in-medicaid-state-drug-utilization-review-dur-and>

²³ Ibid.

²⁴ PhRMA. Accumulator adjustment programs lead to surprise out-of-pocket costs and nonadherence, analysis finds. November 2020. <https://catalyst.phrma.org/accumulator-adjustment-programs-lead-to-surprise-out-of-pocket-costs-and-nonadherenceanalysis-finds>

²⁵ For a more detailed discussion, please see our comment letter on the Notice of Benefit and Payment Parameters for 2021.

cost-sharing assistance is available.²⁶ Growing use of these programs and their potential impact on certain patients, based solely on a medical condition or need for a specific medicine, is concerning in the best case and could run afoul of nondiscrimination requirements. In a survey of commercial health plans conducted by MMIT, payers covering 75 percent of lives had already implemented an accumulator adjustment program and copay maximizer program prior to 2022, and payers covering 13 percent of lives intended to implement copay maximizers after 2022.²⁷ From 2019 to 2022, the prevalence of copay maximizers tripled among commercial patients taking brand autoimmune and multiple sclerosis medicines and doubled among those taking brand oncology medicines.²⁸

In contrast, the ACA aims to increase affordability for health insurance coverage by requiring an annual limitation on out-of-pocket costs for EHB to apply throughout the private health insurance market.²⁹ In the individual and small group market, if a health plan includes covered drugs beyond the number of drugs covered by the EHB benchmark plan, all of these covered drugs are considered EHB and “cost sharing paid for the drugs must count toward the annual limitation on cost sharing,”³⁰ which substantially limits these plans from implementing copay maximizers.

Maximizers exploit the purported loophole in regulatory requirements for non-grandfathered group health plans to deem certain prescription medicines, often specialty medications, as not “essential health benefits” and therefore not subject to the ACA’s annual limit on cost sharing. These programs may discriminate against enrollees who use cost-sharing assistance provided by manufacturers by offering more limited benefits – and higher cost sharing – to them as compared to other enrollees who have other forms of cost-sharing assistance, including family support. While there is no purported clinical reason to designate certain covered drugs as non-EHB and impose higher cost sharing, these copay maximizer programs shift higher costs of accessing these medications onto patients who decide not to enroll in the copay maximizer program or onto manufacturer cost-sharing assistance programs that are intended for and available to patients independently of the copay maximizer program.

²⁶ TrialCard. Co-Pay Accumulators & Maximizers: Your Questions Answered, PT. 3. July 27, 2020. <https://corp.trialcard.com/co-pay-accumulators-maximizers-your-questions-answered-pt-3/>; Drug Channels. Copay Maximizers Are Displacing Accumulators—But CMS Ignores How Payers Leverage Patient Support. May 19, 2020. <https://www.drugchannels.net/2020/05/copay-maximizers-are-displacing.html#:~:text=Under%20a%20copay%20maximizer%2C%20the%20full%20value%20of,it%20reduces%20or%20eliminates%20the%20patient%E2%80%99s%20out-of-pocket%20obligations>

²⁷ MMIT. Copay Accumulator and Maximizer/Patient Assistance Programs Special Report. Prepared for PhRMA. Q3 2022.

²⁸ IQVIA. Five Years and Counting: Deductible Accumulators and Copay Maximizers in 2022. December 2022. <https://www.iqvia.com/-/media/iqvia/pdfs/us/white-paper/2022/five-years-and-counting-deductible-accumulators-and-copay-maximizers-in-2022.pdf>.

²⁹ See Patient Protection and Affordable Care Act § 1302 (c)(1), 42 USC 18022 (c)(3); § 2707(b), 42 USC 300gg-6(b).

³⁰ 84 Fed. Reg. 227 at 289.

The policy that all covered drugs are considered EHB, which applies to the individual and small-group markets, should be extended to all non-grandfathered group health plans, whether insured or self-insured, and regardless of employer size. The extension of this policy will ensure that the ACA's consumer protection on out-of-pocket costs applies, as intended, to all individuals with private health insurance. Therefore, under HHS's authority to define the essential health benefits, HHS should specify that all covered drugs are EHB in all contexts.

Prohibit Coverage Discrimination for Individuals Living with Preexisting Conditions

Alternative funding programs are a type of cherry-picking strategy to avoid individuals with higher health risks, in other words, individuals with preexisting conditions. PBMs and third-party vendors are excluding coverage of certain types of medicines due to the cost of providing coverage of life-saving medication, and, instead, directing those patients to manufacturer or independent patient assistance programs as an alternative to coverage.

Manufacturer patient assistance programs or independent charitable assistance was originally designed to support and assist patients who are truly unable to afford their prescription because they are uninsured or underinsured, meaning they are at high financial risk because they cannot afford their cost-sharing obligations.³¹ In recent years, third parties are marketing these resources to employer health plans as “alternative funding programs” and as an opportunity for “savings” on specialty medications by conditionally removing their employees’ prescription coverage of specialty medications so that those patients appear to “qualify” for the free medications provided by patient assistance programs. The qualification, however, is in appearance only: for example, employer health plans will often reinstate the insurance coverage for the therapy if the patient does not qualify for the patient assistance program.

As we noted in earlier comments in response to HHS's Nondiscrimination in Health Programs and Activities (Section 1557) proposed rule, alternative funding programs are potentially discriminatory for individuals living with disabilities who are prescribed specialty medication.³² These programs exist only for specialty drugs and thus disproportionately affect individuals living with chronic and rare conditions who need these life-saving specialty medications. Individuals living with chronic or rare conditions must undergo additional processes after their claim is denied – without any clinical justification – which delays their access to medicine and potentially puts them at risk of poorer health outcomes. This delay is particularly concerning for those patients living with conditions that require medication to survive.

The ACA sought to protect individuals living with preexisting conditions by requiring that access, affordability, and adequacy of coverage be the same for the healthy and those living with

³¹ See Lavarreda, S. “Underinsurance in the United States: An Interaction of Costs to Consumers, Benefit Design, and Access to Care. *Ann. Rev. Public Health.* (Vol. 32, pg. 471-82).
<https://www.annualreviews.org/doi/pdf/10.1146/annurev.publhealth.012809.103655>.

³² PhRMA. Comments on Section 1557 Nondiscrimination Proposed Rule.
<https://www.regulations.gov/comment/HHS-OS-2022-0012-69039>.

preexisting conditions.³³ Therefore, developing or administering benefit design or coverage in a manner that relies on the possibility of third-party financial assistance or support should be prohibited as this is a type of coverage discrimination.

Market Reforms

Standardized Plan Designs (§ 156.201)

PhRMA supports HHS's 2023 rule requiring qualified health plan (QHP) insurers on the Federally-facilitated Exchange (FFE) and State-based Exchanges on the Federal Platform (SBE-FPs) to offer standardized health plans. Standardized plans can simplify health insurance enrollment in those states by streamlining plan choices and making the shopping experience more patient friendly. Standardized plans contribute to these goals by providing plan options from different insurers with identical cost sharing, allowing shoppers to focus on important differences regarding plan premiums, drug formularies, provider networks, and quality.

Insurance coverage has eroded in the individual market in recent years, due in large part to rising deductibles and coinsurance. In 2021, not only did two out of every three commercially insured patients taking brand medicines fill a prescription in the deductible phase or with coinsurance, but patients who paid for their prescription brand medicines in the deductible phase of their coverage faced costs that were on average nearly eight times higher than patients who filled prescriptions with copays.³⁴ Standardized plans can help ensure that insurers offer plans on Exchanges with predictable and more affordable cost sharing on needed care. Standardized plans can include lower cost sharing than non-standardized plans on specific services by using copayments instead of coinsurance and designate some services eligible for coverage pre-deductible, increasing access to care for patients. Given that these plans are designed to be patient friendly and equitable, PhRMA believes that they should not be allowed to utilize accumulator adjustment programs, which could undermine many of the stated HHS goals of standardized plans for enrollees (please see the discussion of accumulator adjustment programs in the preceding section of this letter).

PhRMA supports the removal of the standardized non-expanded bronze metal-level plans. This plan design lacked pre-deductible coverage, and continuing to require such coverage could cause the plan design to run afoul of the required actuarial value levels. Pre-deductible coverage is important in the face of insurers' increasing demands that patients pay high deductibles before receiving coverage of their medicines. High deductibles can lead to patients rationing their medicine or not taking it at all and suffering devastating consequences to their health. A recent study showed that expanding pre-deductible coverage to the 116 drug classes used to manage

³³ See Public Health Service Act §§ 2702-2705, 42 U.S.C. §§ 300gg-1 to -4.

³⁴ PhRMA. "Deductibles and Coinsurance Drive High Out-Of-Pocket Costs For Commercially Insured Patients Taking Brand Medicines," November 2022. https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Report-PDFs/G-I/IQVIA-Report-High-OOP-for-Brand-Medicines_November-2022.pdf.

chronic conditions – covering roughly 81 percent of the plans’ drug spend – had a “relatively small” impact on plan premiums (1.3-4.7 percent of premiums).³⁵ People managing chronic health conditions should not have to pay a deductible at the pharmacy counter, especially due to the unique patient liability for pharmacy benefits (with cost-sharing due in almost all cases at the point of sale and required to access the medication, instead of the retrospective billing common for most hospital and physician services). Instead, patients should have at least some of their medicines covered by their insurance from day one.

Prescription Drug Tiering in Standardized Plans

Number of Tiers

Standardized plans use four prescription drug tiers: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. This formulary structure facilitates consumers’ understanding and comparison of their coverage options so they can make educated plan choices and face less uncertainty about their cost-sharing obligations. HHS requests comment on the appropriate number of formulary tiers and whether additional tiers should be considered. PhRMA believes that additional tiers would be detrimental to patients, as it would escalate consumer confusion and amplify the difficulty consumers have in choosing a plan, negating some of the benefits of the standardized plan benefit design.

Adverse Tiering

It is encouraging that the Administration is monitoring the practices of adverse tiering and discriminatory benefit design. Formulary tiering can be an appropriate tool for health plans to use when several medically appropriate treatment regimens for a condition are available to patients. Adverse tiering – the practice of putting all or most drugs for a particular condition on the highest cost-sharing tier – is not a legitimate use of formulary tiering because it cannot encourage use of a preferred drug.³⁶ It serves only to shift costs from insurers to patients, particularly for those with chronic conditions and disabilities, or to discourage patients with significant medical needs from enrolling in the first instance. For example, an analysis of exchange plans found that plans placed brand rheumatoid arthritis (RA) drugs on a specialty tier 30% of the time. Additionally, almost all Exchange plans analyzed required coinsurance for medications on the specialty tier with an average coinsurance of 38%. This likely represents a significant cost burden for many patients with RA. Additionally, plans in seven states placed all covered, branded drugs for RA or HIV on a non-preferred or specialty tier at least 50% of the time. Even in plans using copays on higher tiers, copay amounts can be substantial—of plans

³⁵ Fronstin P, Roebuck MC, Fendrick AM. Premium Impact of Expanding Pre-Deductible Coverage to Chronic Disease Management Medications in HSA-Eligible Health Plans. July 14, 2022. <https://www.cbri.org/publications/research-publications/issue-briefs/content/premium-impact-of-expanding-pre-deductible-coverage-to-chronic-disease-management-medications-in-hsa-eligible-health-plans>.

³⁶ Placing certain formulations on the highest cost-sharing tier is also a concerning practice, as new formulations of approved drugs can offer significant advances in therapy.

using copays, the average copay for drugs placed on the specialty tier (\$261) is more than 3 times the average copay for drugs placed on the preferred tier (\$76).³⁷

As noted in the 2024 Draft Letter to Issuers in the FFEs, PhRMA applauds CMS's approach to its adverse tiering review as part of the non-discrimination formulary cost share review for QHPs on FFEs.³⁸ Reviewing whether QHP enrollees have access to drugs or drug classes prescribed to treat chronic conditions cited by CMS— hepatitis C virus, HIV, multiple sclerosis, and rheumatoid arthritis – can ensure that patients needing life-saving and life-improving medication do not face insurer-imposed discriminatory benefit designs that result in patients facing financial barriers to accessing their medication.³⁹ PhRMA suggests that this review proposal be a recommendation for states with their own Exchanges to ensure consistency for all enrollees with QHPs. Moreover, PhRMA recommends expanding the list of chronic conditions and drugs under CMS's adverse tiering review in plan years.

When all medicines to treat a condition require high cost sharing, it can translate into higher costs for patients. A 2015 *New England Journal of Medicine* study found that adverse tiering in HIV coverage among federal exchange health plans had an average annual cost of HIV treatment (the sum of out-of-pocket costs for medicines and insurance premiums) that was more than triple the average cost faced by enrollees in plans that did not practice adverse tiering, with an estimated out-of-pocket annual cost difference of about \$2,000.⁴⁰ Complaints to the HHS Office for Civil Rights document these practices. For example, in Florida, four insurers offering plans on the Exchange classified all or most generic medicines treating HIV as specialty drugs, contrary to medical standards and insurer norms.⁴¹ Likewise, insurers in seven states allegedly did the same by treating the vast majority of HIV medications as specialty drugs that were placed on the highest cost-sharing tier, making the medicines cost-prohibitive and a de facto denial of lifesaving care.⁴² And recently, two HIV organizations filed discrimination complaints against an insurer in North Carolina for placing all of their HIV drugs on the highest cost drug tier.⁴³

³⁷ Unpublished Avalere analysis of tiering and cost sharing in federally-facilitated exchanges (FFE) and state-based exchanges using the federal platform (SBE-FP). September 2022.

³⁸ Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS), 2024 Draft Letter to Issuers in the Federally-facilitated Exchanges, Section 11, pg. 16, Dec. 12, 2022. Available at <https://www.cms.gov/files/document/2024-draft-letter-issuers-508.pdf>.

³⁹ Ibid.

⁴⁰ Douglas B. Jacobs & Benjamin D. Sommers. "Using drugs to discriminate: adverse selection in the insurance marketplace," 372 *New Eng. J. Med.* 399, 401 (2015).

⁴¹ Administrative Complaint filed with the Office of Civil Rights by The AIDS Institute and the National Health Law Program. May 29, 2014. <https://healthlaw.org/wp-content/uploads/2014/05/HIV-OCR-complaint-5-29-14-Final.pdf>.

⁴² Press release. "Center for Health Law and Policy Innovation of Harvard Law School Launching Groundbreaking Campaign to Enforce Health Care Rights for People Living with HIV in Seven States." September 6, 2016. https://chlp.org/wp-content/uploads/2013/12/CHLPI_OCR-Complaint-Press-Release_web.pdf.

⁴³ HIV+HEP Policy Institute and NC AIDS Action Network, Letter to North Carolina Commissioner of Insurance and State Fire Marshall, Mike Causey. Dec. 8, 2022. <https://hivhep.org/wp-content/uploads/2022/12/NC-Discriminatory-Formulary-Complaint-attachments-12.8.22.pdf>. Administrative Complaint filed with the Office of

Moreover, the resulting high cost sharing has the known, entirely foreseeable effect of discouraging sick patients from using needed medicines—or from enrolling in these plans in the first place. In the 2023 NBPP, HHS appropriately defined “adverse tiering” as an example of presumptively discriminatory plan designs.⁴⁴ We encourage the Administration to continue to monitor these adverse actions.

Appropriate Tiering of Drugs

As a complement to continued oversight of adverse tiering, we support the proposal to add a new paragraph (c) specifying that issuers of standardized plan options must place generic drugs in the generic drug cost-sharing tier, unless there is an appropriate and non-discriminatory reason to place them in the specialty drug tier. The behavior of Medicare Part D plan sponsors demonstrate why this type of protection is needed—over time, the percentage of generic drugs placed in the generic tier has decreased from 65% in 2016 to 43% in 2022.⁴⁵ Similarly, the new provision would specify that issuers must place brand name drugs in either the preferred or non-preferred brand tier, unless there is an appropriate and non-discriminatory reason to place them in the specialty tier. We appreciate the Administration’s view that there must be a clinical basis for putting a particular prescription drug in the specialty tier.

Formulary Exclusions

The past decade has also seen a proliferation in the number of medicines excluded from PBM formularies. In 2022, 1,156 unique medicines were excluded from the commercial insurance formularies, a 961% increase from 2014.⁴⁶ Medicines to treat common chronic conditions like diabetes, cardiovascular disease, and depression are frequently excluded from PBM formularies.⁴⁷ PBMs often exclude lower list price options in favor of medicines with higher list prices and large rebates, which have financial implications for patients with deductibles or coinsurance. For some patients, having these medicines on the PBM’s formulary could reduce their out-of-pocket costs by hundreds or thousands of dollars per prescription.⁴⁸ PBMs also increasingly exclude medications to treat complex conditions like cancer, autoimmune disorders, and HIV, even though variation in patient response to treatment for these conditions is well-

Civil Rights by the HIV+HEP Policy Institute and NC AIDS Action Network. Dec. 8, 2022. <https://hivhep.org/wp-content/uploads/2022/12/NC-Discriminatory-Formulary-Complaint-OCR-attachments-12.8.22.pdf>.

⁴⁴ 87 Fed. Reg. 47824 at 27304.

⁴⁵ Avalere. 57% of Generic Drugs Are Not on 2022 Part D Generic Tiers. January 24, 2022. <https://avalere.com/insights/57-of-generic-drugs-are-not-on-2022-part-d-generic-tiers>.

⁴⁶ Xcenda. Skyrocketing growth in PBM formulary exclusions continues to raise concerns about patient access. May 2022. https://www.xcenda.com/-/media/assets/xcenda/english/content-assets/white-papers-issue-briefs-studies-pdf/xcenda_pbm_exclusion_may_2022.pdf.

⁴⁷ Avalere. 57% of Generic Drugs Are Not on 2022 Part D Generic Tiers. January 24, 2022. <https://avalere.com/insights/57-of-generic-drugs-are-not-on-2022-part-d-generic-tiers>.

⁴⁸ Xcenda. “Skyrocketing Growth in PBM Formulary Exclusions Raises Concerns About Patient Access,” September 2020. <https://www.xcenda.com/insights/skyrocketing-growth-in-pbm-formulary-exclusions-raises-concerns-about-patient-access>

documented.⁴⁹ Nearly one in five PBM formulary exclusions target single-source brand medicines for which generic equivalents or biosimilar alternatives are not yet available.⁵⁰

Patients who require treatment with a medicine excluded from a PBM's formulary may be forced to pay the full price for the medicine out of pocket or undertake a burdensome appeals or exceptions process, which may delay initiation of treatment. Patients who change health plans (or employers) can unknowingly lose access to medicines they have been taking for months or years. Although plan sponsors are not required to use their PBM's standard formulary, adopting a custom formulary may result in additional costs through fees or a reduction in rebates the plan sponsor receives from the PBM.⁵¹ According to a survey of PBMs, 85 to 90 percent of large employers use their PBM's standard formulary.⁵²

Physician and patient organizations have protested PBM formulary exclusions because they force stable patients to change therapies without clinical justification, a practice known as non-medical switching.^{53,54} For example, in a letter to CVS Caremark, the Partnership to Advance Cardiovascular Health denounced the PBM's unilateral decision to remove all but one direct oral anticoagulant from its 2022 commercial formulary, calling it "dangerously disruptive for patients currently on therapy." The letter also claimed that CVS Caremark's action would "disproportionately affect historically disadvantaged patients" and "unquestionably exacerbate health equity concerns that exist in cardiovascular care."⁵⁵ HHS should monitor formulary exclusions and evaluate whether they constitute impermissible discrimination.

HHS should also consider including protections against mid-year formulary changes such as non-medical switching for QHP enrollees. Non-medical switching may occur when a PBM makes a change to the formulary mid-year. PBMs may add utilization management restrictions, assign medicines to higher cost sharing tiers, or drop medicines from the formulary at any time, often with as little as 30- or 60-days' notice to patients.⁵⁶ As a result, patients may find that the medicines they've been taking for months or years – which they understood to be on formulary

⁴⁹ Ibid.

⁵⁰ Ibid.

⁵¹ Rayburg R. "Three Proactive Strategies for Reducing Waste in Your Plan's Formulary. Pharmaceutical Strategies Group." August 14, 2019. <https://www.psgconsults.com/blog/three-proactive-strategies-for-reducing-waste-in-your-plans-formulary>

⁵² Fein AJ. "The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers." Drug Channels Institute. March 2022.

⁵³ The Doctor-Patient Rights Project. "The De-List: How Formulary Exclusions Deny Patients Access to Essential Care." December 2017.

⁵⁴ Wong M. "Non-Medication Switching is a Patient Safety Issue." Physician-Patient Alliance for Health & Safety. March 22, 2022. <https://ppahs.org/2022/03/non-medication-switching/#more-39332>

⁵⁵ Letter from Ryan Gough, Executive Director, Partnership to Advance Cardiovascular Health, to Troyen Brennan MD, Chief Medical Office, CVS Health. December 2, 2021. <https://static1.squarespace.com/static/56e6efdb5559866c54beb696/t/61b3b6a6916aab0fc1bee793/1639167659313/CVS+Switch+Letter+Final.pdf>

⁵⁶ Gill LL. "When Your Insurer Drops Your Prescription Drug." Consumer Reports. July 2, 2020. <https://www.consumerreports.org/prescription-drugs/when-your-insurer-drops-your-prescription-drug/>.

at the time they enrolled in their health plan – suddenly have significantly higher out-of-pocket costs or are no longer covered. Recognizing that formulary stability is important for beneficiaries to maintain access to needed therapy, the Medicare Part D program has robust protections against mid-year formulary changes. Part D plan sponsors may not remove a medicine from their formulary, increase the cost sharing, or impose new or more restrictive utilization management requirements mid-year without seeking prior approval from CMS and must exempt beneficiaries taking the affected medicine for the remainder of the year.⁵⁷ Additionally, non-medical switching decisions between available products should be in the hands of physicians and their patients after discussing the risks and benefits based on clinical information. PhRMA urges CMS to provide similar protections for QHP enrollees.

Limits for Non-Standardized Plan Options (§ 156.202)

PhRMA supports limiting the number of non-standardized plan options in the FFE and SBE-FPs to two per product network type and metal level, per service area, as proposed. As the Administration has documented in the 2023 NBPP and in this year's proposal, consumers can be paralyzed by choice overload and either abandon the enrollment process or make suboptimal decisions.⁵⁸ The explosion of plan offerings – from roughly 26 per average exchange consumer in 2019 to 114 in 2023⁵⁹ – provides plentiful choice for consumers but many of these plans have indecipherable differences and require patients to have a high degree of health literacy to do intense investigation of their options. Choice overload is particularly problematic for low-income enrollees who face among the greatest number of near-duplicate plans.⁶⁰ Reasonable limits can foster a more patient-friendly Exchange and shopping experience.

However, transitioning to a more limited menu of plan options is estimated to cause more than one-quarter of enrollees (2.72 million) to have their plans discontinued, requiring them to shop for or be crosswalked by issuers to a new plan. In these cases, HHS should take into consideration enrolling patients in plans with the same provider network, as is proposed for the revised enrollment hierarchy for annual eligibility enrollment determinations (155.335(j)). This might be considered in tandem with the limitation on non-standardized plans, such that non-standardized plans for which there is no equivalent provider network could continue, even if it means the total number of plans from the issuer exceeds two. HHS could also consider a transitional cost-sharing policy that permits patients to continue seeing a provider, at in-network cost-sharing, for a course of treatment if the provider is newly out-of-network due to a plan change required to comply with the new limitation on non-standardized plan options.

⁵⁷ Centers for Medicare & Medicaid Services. “Medicare Prescription Drug Benefit Manual: Chapter 6 – Part D Drugs and Formulary Requirements.” <https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/part-d-benefits-manual-chapter-6.pdf>.

⁵⁸ 87 Fed. Reg. at 78280 (Dec. 21, 2022).

⁵⁹ 87 Fed. Reg. at 78281 (Dec. 21, 2022).

⁶⁰ Ibid

HHS also seeks comment on reinstating a meaningful difference standard as an alternative to limiting the number of non-standardized plans. Under this policy proposal, the Exchange would group plans by issuer ID, county, metal level, product network type, and deductible integration type, and then evaluate whether the plans are meaningfully different, as determined by whether their deductibles differ by more than \$1,000. The Administration might also consider combining this proposal with limitations on non-standardized plans, such that an issuer could offer more than two non-standardized plans if additional plans meet the meaningful difference standard. This would limit the number of plan options while ensuring the patients have a wide array of unique plan offerings.

Plan Marketing Variations (§ 156.225)

The proposed rule raises examples of some Exchange plan names being inaccurate or misleading in offered benefits, deductibles or other factors relevant to patient choice. Patients are best served by receiving accurate and straightforward information in all elements of the plan comparison and selection process, and we support requiring this information to be accurate. As with differentiating between standardized and non-standardized plans, requiring a format for plan marketing names may lead to more appropriate plan choices based on the different needs of patients.

Network Adequacy (§ 156.230)

PhRMA supports instituting appointment wait time standards, as was approved in the 2023 NBPP and is to be implemented in 2024. We urge rigorous enforcement of this standard, as well as the time and distance standards newly in place in 2023. Further, we urge HHS to expand the network adequacy standards to institute reviews for pharmacies. Network adequacy standards can indirectly impact access for certain prescription drugs, such as when a prescription drug is covered by a plan, but it needs to be dispensed or administered by specialized providers who are out-of-network, or by a specialty pharmacy. Specialized providers and specialty pharmacies are often utilized when therapies for complex, chronic conditions require special management, including additional monitoring and support services that retail pharmacies may not be able to offer. If a patient receives an otherwise covered drug from an out-of-network provider or pharmacy, which might be the only way to receive the drug locally, the plan could consider the medicine out-of-network and might not count cost sharing toward the maximum out-of-pocket limit, creating an affordability barrier. Over the past decade, PBMs have implemented narrow networks that incentivize or require patients to fill prescriptions at specific pharmacies that are either affiliated with the PBM or are compelled to accept lower reimbursement as a condition of network participation.⁶¹ Overly narrow pharmacy networks can have the practical impact of dissuading patients with certain complex, chronic conditions from enrolling in a plan in the first place, and thus, the adequacy of pharmacy networks should also be included in HHS's reviews.

⁶¹ Fein AJ. "The 2022 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers." Drug Channels Institute. March 2022.

Additionally, we are concerned about the accelerated growth of “pharmacy deserts.” Unfavorable PBM reimbursement terms have resulted in an unsustainable environment for many community pharmacies. The combination of these dynamics has resulted in pharmacy closures across the country. One study showed that 630 rural communities with at least one retail pharmacy in 2003 had none in 2018.⁶² Lack of pharmacy accessibility is not limited to rural areas. The lack of available pharmacies is of particular concern for the urban poor, who are less likely to use online pharmacies and more likely to let their drug regimens lapse when they can't get medication locally.⁶³ Additionally, a recent study on the geographic accessibility of pharmacies based on their racial/ethnic composition in the thirty most populous cities in America found persistently fewer pharmacies located in Black and Hispanic/Latino neighborhoods than in white or diverse neighborhoods. In 2015, there were disproportionately more “pharmacy deserts” in Black or Hispanic/Latino neighborhoods than in white or diverse neighborhoods, and Black and Hispanic/Latino neighborhoods were more likely to experience pharmacy closures compared with other neighborhoods.⁶⁴

Pharmacy closures are associated with an immediate and sustained reduction in medication adherence, leading to poorer health outcomes for patients in impacted communities.⁶⁵ For example, community pharmacy closures were associated with a 50 percent increase in a patients' likelihood of abandoning their cardiovascular medicines.⁶⁶

HHS should investigate this growing trend and consider network adequacy standards that ensure all patients have access to a local pharmacy to fill needed prescriptions. PhRMA supports the proposals that HHS has announced with evaluating network adequacy of Exchange plans prior to their certification.⁶⁷ We urge HHS to enforce network adequacy standards including reviewing the network adequacy review process of states that perform their own plan management functions. Given the role of that an adequate network of providers can play with improving health equity, we urge HHS to provide strong oversight and enforcement of their proposed network adequacy standards.

⁶² Salako A, Ullrich F, Mueller KJ. Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018. <https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf>.

⁶³ Axios. The Growth of “Pharmacy Deserts”. January 2021. <https://www.axios.com/pharmacy-deserts-cities-prescriptions45c32271-37ac-4105-b1bb-e2d2436b88c1.html>.

⁶⁴ Guadamuz, Jenny S., et al. "Fewer Pharmacies In Black And Hispanic/Latino Neighborhoods Compared With White Or Diverse Neighborhoods, 2007–15: Study examines pharmacy “deserts” in Black and Hispanic/Latino neighborhoods compared with white or diverse neighborhoods." *Health Affairs* 40.5 (2021): 802-811.

⁶⁵ Qato DM et al. Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults. *JAMA Network Open*. 2019;2(4):e192606.

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2730785>; Pednekar P, et al. Comparing Medication Adherence Rates Between Pharmacy Desert And Non-Desert Areas Among Elderly In Pennsylvania. *Value in Health*, 19(3):2016. [https://www.valueinhealthjournal.com/article/S1098-3015\(16\)01321-8/fulltext](https://www.valueinhealthjournal.com/article/S1098-3015(16)01321-8/fulltext).

⁶⁶ Qato DM et al. Association Between Pharmacy Closures and Adherence to Cardiovascular Medications Among Older US Adults. *JAMA Network Open*. 2019;2(4):e192606.

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2730785>.

⁶⁷ See 87 Fed. Reg. 88. May 6, 2022.

Essential Community Providers (§ 156.235)

PhRMA supports HHS's proposal to require QHP issuers to include at least 35 percent of all available FQHCs and 35 percent of available family planning providers within their service area in their network as essential community providers (ECP). We believe the existence of a more robust standard will benefit low-income and medically underserved populations who are principally serviced by ECPs. This has the potential to make an incremental improvement in the equitable distribution of health care resources. Further, adding two new ECP categories -- mental health facilities and substance use disorder treatment centers and rural emergency hospitals -- will make these facilities more available in the communities they serve by ensuring that more are in-network.

Enrolling and Staying Enrolled in Health Insurance (Part 155)

PhRMA supports Exchange policies that help people enroll and stay enrolled in coverage. Enrollment can be a confusing, complex and intimidating process for some people, especially for those with low socioeconomic status, who are more likely to have low health literacy.⁶⁸ Patients with low health literacy have trouble understanding what a deductible, copayment or coinsurance is, and can have difficulty determining which plan is best suited to their individual medical needs beyond simply the monthly premium. As such, PhRMA supports the proposal to crosswalk enrollees currently in bronze plans to an equivalent silver plan with the same or lower premium. Some enrollees will find immense benefit in being guided to a plan that is identical -- with consideration of the provider network -- but that has a lower deductible due to cost-sharing reductions. Lower deductibles and out-of-pocket maximums can allow enrollees to access medications and increase medication adherence by lowering their cost-sharing obligations.

The proposed rule also has policies to promote continuous coverage in other ways that PhRMA supports. Such policies include relying on applicant attestations for life changes when IRS income information is unavailable and automatically providing a 60-day extension to resolve income inconsistencies. These policies can help applicants enroll and can promote equity as research indicates that burdensome requests for income documentation disproportionately affect applicants with annual income lower than \$25,000 and may pose a strain on Black or African American applicants who are less likely to complete the income inconsistency process.⁶⁹ More individuals and families could enroll and maintain enrollment with the policy to change the income reconciliation rule for IRS returns to two consecutive years instead of one. Moreover, the proposed policy to allow young adults up to age 26 to maintain their Exchange coverage until the end of the coverage year, codifies the current practice and could prevent often difficult mid-year coverage switches, changed premiums, and the potential reset of deductibles. Requiring timely delinquency notices prior to coverage termination could also keep people enrolled by giving them adequate time to rectify a premium deficiency.

⁶⁸ HRSA, "About Health Literacy," accessed at: <http://www.hrsa.gov/publichealth/healthliteracy/healthlitabout.html>.

⁶⁹ 78 Fed. Reg. at 87258

PhRMA supports the proposed changes to the special enrollment period (SEP) rules as they are timely and could help people in some states that will have a lengthy unwinding of the Medicaid continuous coverage requirement. Specifically, allowing people to have 90 days, instead of 60 days, to enroll after loss of Medicaid or the Children's Health Insurance Program (CHIP), changing the coverage effective date for people who report future coverage loss, and allowing the entire family to enroll when one person becomes eligible would all provide a soft landing to more people who are experiencing changes in life circumstances. We also support expanding the ways in which people can prove they have been affected by plan display errors.

Consumer support to help people understand their coverage options and enroll in coverage is very important in guiding people to the best plan for them. As such, we support policies to allow more unsolicited Navigator contact with consumers. Agents and brokers also play a core role in enrollment, but we appreciate the proposed requirements to maintain the integrity of these interactions by proving enrollee consent and reviewing allegations when there is evidence of fraud.

Risk Adjustment (Part 153)

We recognize that as net drug prices change— and in some cases, decline—it may be appropriate to recalibrate or constrain the coefficients for prescription drug categories (RXC's) to reflect the current market environment. While these recalibrations are appropriate if they are necessary to improve the model's predictive accuracy, we are concerned with HHS's assertion that without such a change, insurers would game the model by encouraging providers to prescribe particular treatments when they are unnecessary, as HHS implies with its proposal regarding the pricing adjustment for hepatitis C drugs. The professional independence and ethical standards of health care providers would prevent them from prescribing drugs that they did not believe were medically necessary and appropriate. We think the much greater concern is that the risk adjustment model could fail to adequately compensate issuers for enrollees with serious chronic conditions, and this could cause issuers to discourage enrollment by these patients, or design formularies or utilization management practices to make it difficult for patients to access innovative medicines. Thus, we encourage HHS to evaluate the model continually to ensure it fully captures the cost of the current standard of care for conditions in the model.

PhRMA appreciates the opportunity to provide comments regarding this proposed rule. Please feel free to contact Emily Donaldson at 202-835-3420 or edonaldson@phrma.org if we can provide any further information or if you have any questions about the topics discussed in our comments. We look forward to continuing to engage with the HHS on these important issues.

Sincerely,



Emily Donaldson
Deputy Vice President
Policy and Research



Sandy Ahn
Assistant General Counsel

NATIONAL BOARD OF TRUSTEES

Maureen Nugent Franco
Chair

Silas P. Norman, MD, MPH
Chair-Elect

Jerry D. Klepner
Immediate Past Chair

Julie A. Wright Nunes, MD, MPH
Chair, Medical Affairs

John F. Hanley, CFA
Treasurer

William J. Schuyler
Secretary

Frances E. Ashe-Goins, RN, MPH, FAAN
Kenneth R. Bridges, MD
Oliver T. Brooks, MD
Hon. Donna M. Christensen, MD
Michael W. Flood
Jamie A. Green, MD
Brian Krex, Esq.
Gregory P. Madison
Pamela W. McNamara
Elaine Milem
John D. Ring, CPA, CGMA
Lisa A. Robin
Sean P. Roddy, CPA, CMA, CGMA, MBA
Malay B. Shah, MD
Andrew M. Shore, JD
Melanie J. Turieo
Priscilla VanderVeer
Heidi L. Wagner, JD

Gail S. Wick, MHA, BSN, RN, CNNe,
Trustee Emerita

LaVarne A. Burton
President & CEO, ex-officio

January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244–1850

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

Dear Administrator Brooks-LaSure:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule referenced above.

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

AKF appreciates CMS' continued efforts in this rule to provide quality, affordable coverage, minimize administrative burden, ensure program integrity, and advance health equity for consumers purchasing Affordable Care Act (ACA) marketplace coverage. Our comments on specific CMS proposals are below.

Standardized Plan Options and Non-Standard Plans

AKF continues to support CMS' policy requiring insurers to offer standardized plan options on the federally-facilitated marketplace (FFM) and state-based

marketplaces on the federal platform (SBM-FPs). As we noted in our comments on the Notice of Benefit and Payment Parameters for 2023, requiring standardized plan options will improve affordability by providing greater access to pre-deductible coverage and requiring copays instead of coinsurance for certain services and for all drug tiers. People with chronic conditions such as chronic kidney disease, who often also have other comorbidities, have greater health needs, and may need access to high-cost drugs. Using copays instead of coinsurance for certain provider visits and for all drug tiers in standardized plans will provide improved cost predictability for consumers when choosing a plan. Because kidney disease disproportionately affects communities of color and other underserved populations, standardized plan options will help address health disparities by providing another way to lower cost barriers for needed services and treatments for kidney disease and other comorbidities. Standardized plans will also improve and simplify the plan shopping experience by making it easier to draw meaningful comparisons between plans.

With the consumer in mind and to ensure the marketplaces make it easier for them to make informed choices and to mitigate plan choice overload, we support CMS' proposal to limit the number of non-standard plans that issuers can offer through the FFM or SBM-FPs to two per product network type and metal level, per service area. We believe this is a reasonable solution to the problem of plan choice overload, which as CMS notes can lead to poor enrollment decisions or forgoing enrollment due to the complexity of deciphering health insurance information. Several states already limit the number of non-standard plan offerings, and there has been no indication that it has led to reduced competition, innovation, or insurer participation in those state marketplaces. Limiting the number of non-standard plans offerings will make it easier for consumers to differentiate between their plan options and will encourage insurers to offer truly innovative products that meet the health care needs of the consumer.

We appreciate that CMS intends to maintain a large degree of continuity with its approach to the design of standardized plan options that were finalized in the 2023 Payment Notice, with some proposed updates. AKF supports the proposal to require that standardized plans include all covered generic drugs in the generic tier or the specialty tier (if there is an appropriate and non-discriminatory basis for doing so) and all covered brand name drugs in a brand name drug tier (tiers 2 or 3) or the specialty tier (if there is an appropriate and non-discriminatory reason for doing so). This would help provide clarity for patients on where and how a drug is covered. However, in the event a brand name drug in a higher tier is cheaper than the generic, CMS should ensure that a patient has access to whichever drug is less expensive and they should be able to pay that lesser amount.

Network Adequacy

AKF appreciates CMS' continued implementation of strong network adequacy standards, which are necessary to achieve health equity and to enhance consumer access to quality, affordable care through the marketplaces. We continue to support the evaluation of plan networks using quantitative time and distance standards, and we support CMS' proposal to implement wait time standards in 2024. We also support CMS' plan to continue to require insurers to identify whether

their in-network providers offer telehealth services, and we strongly support the proposal to require all marketplace plans to use a network and comply with all network adequacy standards. Currently, marketplace plans are not required to use a network, and if a plan does not, it is exempt from network adequacy standards (although it is still subject ACA statutory requirements for enrollee access to providers). Requiring all plans to use a network and comply with network adequacy standards will ensure consumers can better compare plan options, reduce their risk of exposure to high cost sharing, and ensure consistent enforcement of ACA consumer protections.

To further strengthen CMS' network adequacy standards, we reiterate our recommendation that CMS evaluate networks for how well they provide access to culturally and linguistically appropriate care. The evaluation would ensure providers can meet the language needs for consumers with limited English proficiency and provide culturally appropriate care that is attuned to the diverse background of a community, including populations that have been traditionally underserved.

We also recommend that CMS strengthen standards and improve oversight of plan provider directories to ensure they are up-to-date and accurate, which is critical in helping consumers make informed decisions in choosing a plan.

Finally, we recommend that dialysis facilities be included in the list of facility specialty types in which network time and distance standards apply. We appreciate that nephrology and vascular surgery are included in the list of provider specialty types in which time and distance standards apply, but dialysis is also a critical and necessary part of the continuum of care for people with kidney disease, and that should be reflected in the network adequacy standards.

Oversight of Agents, Brokers, and Web-brokers

AKF supports CMS' proposals to improve the oversight of agents, brokers, and web-brokers that sell marketplace plans, including:

- Allowing additional time for CMS to review evidence in cases that will determine whether to suspend or terminate an agent, broker, or web-broker's authority to assist consumers in purchasing marketplace coverage.
- Requiring agents, brokers, and web-brokers to document the eligibility information in a consumer's application has been reviewed by and confirmed to be accurate by the consumer or their authorized representative.
- Requiring agent, brokers, and web-brokers to document that they have received consent from the consumer to provide assistance in the first place.

To further improve the oversight of agents, brokers, and web-brokers and to help protect consumers from being misled in enrolling in coverage, we recommend that CMS prohibit agents, brokers, and web-brokers that sell marketplace products from marketing non-ACA compliant products (such as short-term limited duration plans) during the ACA open enrollment period.

Special Enrollment Periods

AKF appreciates CMS' efforts to reduce barriers to coverage and to mitigate the risk of coverage gaps for individuals, particularly those who may lose Medicaid coverage in the upcoming months as the Medicaid continuous enrollment requirements implemented during the COVID-19 public health emergency end. Specifically, we support:

- CMS' proposal to allow marketplaces the option to provide an earlier effective date for an individual who enters a special enrollment period (SEP) because they are losing non-marketplace coverage.
- CMS' proposal to allow marketplaces to extend their SEP window for individuals losing Medicaid or CHIP coverage from 60 days to 90 days.

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. AKF supports this policy.

User Fee Rates for the 2024 Benefit Year

CMS proposes Qualified Health Plan (QHP) issuer user fee rates for the 2024 plan year of 2.5% of total monthly premiums for the FFM and 2.0% for SBM-FPs. These rates are 0.25 percentage points lower than they were in 2022-2023. We appreciate CMS' commitment to ensuring the issuer user fee is adequate to sustain essential marketplace-related activities, such as consumer information and outreach programs, and we appreciate CMS' increased spending on these activities in recent years following several years of diminished funding. However, we recommend that CMS consider further investment in essential marketplace functions and suggest user fee levels be set at the higher levels that were implemented before 2022.

Thank you for the opportunity to provide comments on this proposed rule.

Sincerely,



Holly Bode
Vice President of Government Affairs

January 30, 2023

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.
Board Chair

Donna Thompson
Chief Executive Officer

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

For more than 25 years, Access Community Health Network (ACCESS) has been on the frontlines of **community-based health care**. ACCESS provides a continuum of care model that connects patients to health care resources both within and beyond the walls of our 35 federally qualified health centers (FQHCs).

ACCESS' services are designed to address the health of our underserved communities in such areas as preventive care, chronic disease management, and support services. To address patients' comprehensive health needs, ACCESS physicians, nurse practitioners, midwives and other providers are teamed with outreach staff, case managers, social workers and substance abuse counselors to advance a continuum of care.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. In 2022 our patient population was 16% private coverage and 65% Medicaid. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. ACCESS strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

ACCESS welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.
Board Chair

Donna Thompson
Chief Executive Officer

Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

The CMS' proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. ACCESS recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, ACCESS recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” ACCESS recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP

¹ Section 1311(c)(1)(C)

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.

Board Chair

Donna Thompson

Chief Executive Officer

in that category is available...”² but given the crucial role health centers play in delivering primary care services, ACCESS believes that these good-faith contracts should extend to all FQHCs in their service area.

ACCESS recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. ACCESS recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, transportation, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.
Board Chair

Donna Thompson
Chief Executive Officer

II. Reducing Barriers to Enrollment and Financial Assistance

ACCESS strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options ACCESS' appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. ACCESS appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

ACCESS also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person.>

⁶ [https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1\).](https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1).)

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.

Board Chair

Donna Thompson

Chief Executive Officer

meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

ACCESS also appreciates CMS’ proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

ACCESS appreciates the Administration’s continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ ACCESS has been able to leverage this funding in Illinois to expand the benefits enrollment assistance that we can provide to our communities. Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as “billable providers” and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.

Board Chair

Donna Thompson

Chief Executive Officer

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, ACCESS requests that they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. ACCESS ‘also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.

Board Chair

Donna Thompson

Chief Executive Officer

ACCESS supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

ACCESS supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, ACCESS applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and ACCESS also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.

Board Chair

Donna Thompson

Chief Executive Officer

insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. ACCESS appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

ACCESS' also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. ACCESS appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

ACCESS recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection ACCESS supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an

Administrative Offices

600 W. Fulton Street
2nd Floor
Chicago, Illinois 60661
phone: 312.526.2200
www.achn.net

Thomas P. FitzGibbon, Jr.

Board Chair

Donna Thompson

Chief Executive Officer

unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Dr. Tariq Butt, VP of Government Affairs, at tariq.butt@achn.net.

Sincerely,





January 30, 2023

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

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

Dear Secretary Becerra and Administrator Brooks-LaSure:

The Cystic Fibrosis Foundation thanks the Department of Health and Human Services (HHS) for the opportunity to comment on the Notice of Benefit and Payment Parameters (NBPP) for 2024 proposed rule. The Cystic Fibrosis Foundation is a national organization dedicated to curing cystic fibrosis (CF). We invest in research and development of new CF therapies, advocate for access to care for people with CF, and fund and accredit a network of specialized CF care centers.

Cystic fibrosis is a life-threatening genetic disease that affects close to 40,000 children and adults in the United States. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. If left untreated, infections and exacerbations caused by CF can result in irreversible lung damage, and the associated symptoms of CF lead to early death, usually by respiratory failure. Through careful, aggressive, and continuously improving disease management, the average life expectancy for people with cystic fibrosis has risen steadily over the last few decades. This milestone reflects over 50 years of hard work to improve CF treatments, develop evidence-based standards of care, and encourage adherence to a lifetime of chronic care. However, this system of care and the improvements in length and quality of life for those with CF can only be realized if patients have access to adequate and affordable insurance.

Thank you for the opportunity to submit comments on the Notice of Benefits and Payment Parameters for 2024 Proposed rule. The CF Foundation provides the following recommendations.

Network Adequacy

As noted in our 2023 Notice of Benefits and Payment Parameters comments, the CF Foundation commends HHS for reexamining federal network adequacy standards for plans offered through the Federally Facilitated Marketplace (FFM). We are encouraged by the extensive requirements and oversight procedures implemented in the final 2023 NBPP and that HHS is revisiting the appointment wait time standards. In 2023 final rule, HHS delayed implementation of this standard until 2024, citing concerns about compliance burden on issuers. Establishing standards specifying the maximum number of days enrollees may be required to wait for a provider appointment will add an important dimension to network adequacy review that is not captured by other network rules. Individuals with CF rely on access to a network of specialized providers that are critical for obtaining high-quality care. In CF, waiting too long to see a specialist could give a pulmonary exacerbation time to develop and become life threatening and timely access to providers is essential for maintaining patients' health. We support HHS's approach to collect data from specialists on what would be appropriate for their patient population before setting such a long wait standard.

Furthermore, as HHS considers how to improve network oversight further, the CF Foundation urges the department to scrutinize networks for their ability to provide culturally- and linguistically-competent 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, to ensure individuals with limited English proficiency can obtain timely care in their preferred language. It also means networks must 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, and LGBTQ individuals. Further, to enable consumers to identify the plans and providers likely to meet their needs, qualified health plans (QHPs) must be required to indicate in their provider directories the languages, other than English, which are spoken by a provider and/or their staff.

Prohibiting Mid-Year Terminations for Dependent Children Who Reach Maximum Age

In the proposed rule, HHS would codify the requirement to provide more clarity for participating issuers that dependent children maintain coverage until the end of the plan year in which they turn 26. For families that receive advanced premium tax credits (APTCs), the marketplace makes eligibility determinations for the entire plan year. For young adults with cystic fibrosis enrolled on a marketplace plan with their families, there is a chance the APTCs are more generous or the plan is more robust than if the individual enrolls on their own. Furthermore, this prevents young adults with CF who have high cost of care from restarting their cost-sharing requirements mid-year, which could add significant out-of-pocket expenses. The CF Foundation strongly supports finalizing this requirement.

Special Enrollment Periods

The CF Foundation strongly supports the proposed changes to expand special enrollment periods (SEPs). These issues will be particularly important given the upcoming changes related to the continuous coverage provisions for the COVID public health emergency and transition to marketplace coverage.

First, current rules allow a consumer who knows they will lose non-marketplace coverage within the upcoming 60 days to use a SEP to select a marketplace plan in advance of the loss of coverage. HHS is proposing to modify the loss-of coverage SEP to permit exchanges to require QHPs issuers to start coverage one month earlier in case where the old coverage ends before the end of the month. The CF Foundation strongly supports this provision as it will allow consumers to start coverage sooner and avoid a gap.

In addition, HHS is proposing to extend the loss of coverage SEP enrollment window following loss of Medicaid coverage from 60 days to 90 days, in order to provide consumers more time to reestablish eligibility for Medicaid coverage or enroll in a marketplace plan. We strongly support this proposal, as it will minimize gaps in coverage. Separate from this proposed rule, we strongly support HHS's announcement of 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.

Finally, as HHS evaluates potential changes and improvements to SEPs in future rulemaking, the Department is considering whether to provide an SEP to consumers whose providers leave their network mid-year. Significant network changes, whether it is initiated by the QHP issuer or the provider, can occur at any point during the year. The Department notes that under Medicare Advantage (MA), individuals affected by a significant change in their plan's provider network are eligible for an SEP that permits re-enrollment into another MA plan or Traditional Medicare. The CF Foundation believes that an enrollee who is impacted by a provider contract termination to be someone who is experiencing an exception circumstance, and should be eligible for a new SEP. Access to an accredited CF care center is critical for obtaining medically necessary and high-quality care for people with CF. If the CF care center's hospital or health system terminates its contract with a QHP, patients should be eligible for an SEP so they can find a plan that meets their care needs.

Standardized Plan Options

Standardized health plan designs could offer numerous advantages to people with CF. We strongly support HHS's implementation in 2023 to require issuers to offer at least one standardized plan at every product network type, metal level, and in every services area where the issuer also offers non-standardized plans.

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. In addition, standardization improves affordability in the marketplace by ensuring that consumers always have access to at least one plan that exempts certain important services and drugs from deductibles. We also support requiring plans to use fixed copays instead of coinsurance, which is often more affordable for people with CF.

Due to these benefits, we strongly support HHS to finalize its proposal to limit the number of non-standard plans that insurers can offer. As noted in the proposed rule, the number of plans available to consumers through the marketplace has increased dramatically over time, estimating shoppers seeking 2023 coverage were tasked with choosing among well over 100 plans, on average. Limiting the number of non-standardized plans would reduce the risk of choice overload while making it easier for consumers to make informed choices for themselves, and the CF Foundation strongly supports this limitation. In the states that have already limited non-standard plan offerings, there is no indication such limits have reduced competition, insurer participation, or plan innovation.

Advance Premium Tax Credit Changes

Under the Affordable Care Act (ACA), APTC eligibility is determined using both the consumers attested income and tax return data provided by the Internal Revenue Service (IRS). Currently, exchanges must treat missing tax data as though it is inconsistent with attested income and thus creates a data matching issue. There are many reasons why tax data may not be available at no fault of the consumer, and this

current policy disproportionately affects low-income consumers, The CF Foundation supports HHS's proposal to allow exchanges to rely on attested income to determine APTC eligibility.

Furthermore, HHS proposes to modify the rules for denying APTC to consumers who have failed to file a tax return and reconcile APTC received in the past. Rather than denying APTC when the IRS indicates a consumer has failed to reconcile APTC for a single year, exchanges would only deny APTC when the IRS reports a consumer has failed to reconcile for two consecutive years. The CF Foundation strongly supports this change in policy.

The proposed APTC eligibility changes will help ease the cost burden for people with CF who rely on the individual marketplace for coverage and likely help prevent or minimize loss of coverage.

Standards for Agents, Brokers, and Web-brokers

The CF Foundation strongly supported HHS's final rule changes in the 2023 NBPP that tightened standards of conduct for agents, brokers, and web-brokers, as well as increased transparency, clarification of standards and prohibited business practices, and conflict of interest disclosures. We appreciate HHS further requiring agents, brokers, and web-brokers to document that the eligibility information contained in a consumer's application has been reviewed and confirmed to be accurate, as well as requiring these entities to document that they received consent from the consumer to provide assistance in the first place. Agents and brokers generally have not duty to act in the best interest of consumers, and therefore we appreciate the steps HHS is taking to improve consumer experience and mitigate the risk.

However, more action can be done. As mentioned in our 2023 NBPP comments, agents and brokers should also have an affirmative duty to screen and refer 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.

Copay Accumulator Programs

The CF Foundation is disappointed HHS has failed to address copay accumulator adjustment policies in this proposed rule. Accumulator programs prevent third-party payments from counting towards deductibles and out-of-pocket limits and therefore increase out-of-pocket costs for patients—which can cause people with CF to forgo needed care and lead to adverse health outcomes. According to a survey conducted by George Washington University of over 1,800 people living with CF and their families, nearly half reported delaying or forgoing care—including skipping medication doses, taking less medicine than prescribed, delaying filling a prescription, or skipping a treatment altogether—due to cost concerns.¹ Because CF is a progressive disease, patients who delay or forgo treatment face increased risk of lung exacerbations, irreversible lung damage, and costly hospitalizations.

Accumulator programs also place additional financial strain on people with CF who are already struggling to afford their care. More than 70 percent of survey respondents indicated that paying for health care has caused financial problems such as being contacted by a collection agency, filing for bankruptcy, experiencing difficulty paying for basic living expenses like rent and utilities, or taking a second job to make ends meet. And while three quarters of people received some form of financial assistance in 2019 to pay for their health care, nearly half still reported problems paying for at least one CF medication or service in that same year.

¹ https://hsrsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1056&context=sphhs_policy_briefs

We understand the challenge insurers face in managing the rising cost of drugs, and that copay assistance programs mask bigger cost and affordability issues in the health care system. However, cost containment strategies that further burden patients are unacceptable. Accumulators are especially challenging for a disease like CF, which has no generic options for many of the condition's vital therapies. The situation has become even more dire as a company that manufactures CF therapies recently reduced the amount of copay assistance available for people enrolled in accumulator programs.

Therefore, we urge HHS to include a provision in the final rule requiring insurers and pharmacy benefit managers (PBMs) count all copayments made by or on behalf of an enrollee toward the enrollee's annual deductible and out-of-pocket limit.

The CF Foundation appreciates the opportunity to provide comments on the proposed rule. We look forward to working with HHS on these critical issues to ensure access and affordability for people with CF.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mary B. Dwight', with a stylized, flowing script.

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy
Cystic Fibrosis Foundation

Washington Health Benefit Exchange Comments: Proposed Federal Rule – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 – CMS-9899-P

The Washington State Health Benefit Exchange (Washington or the Exchange) submits comments about the proposed Notice of Benefit and Payment Parameters for 2024 (Payment Notice), published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) on December 21, 2022.

The Exchange greatly appreciates CMS's commitment throughout the proposed 2024 Payment Notice to prioritize continuous coverage for consumers, reduced choice overload, and enrollment in plans that maximize affordability while maintaining patient-provider relationships. The Exchange is supportive of the intent behind many of the proposed changes and appreciative of CMS's renewed commitment to protecting and strengthening the Affordable Care Act.

Washington appreciates CMS's continued commitment to preserving flexibility for state-based exchanges to make decisions best tailored to advance efficiency and innovation at the state level. We appreciate the Administration's customer-focused proposals related to agent and broker oversight, standard plans, continuity of coverage, and re-enrollment hierarchy. We think these proposals serve to help consumers select, enroll, and remain in a plan that meets their health needs. However, the Exchange urges CMS to reconsider some aspects of the proposals included in this Payment Notice that impose additional burdens on state-based exchanges, such as the IPPTA.

The Exchange respectfully expresses concern that the timeframe for submitting comments on the proposed Payment Notice is inadequate to solicit thorough stakeholder feedback on these complex and impactful proposed Exchange regulations. We urge CMS to return to its previous practice of publishing these important annual Exchange proposed regulations with a full 60-day comment period and to build adequate time into the publication timeline to allow for thorough consideration of the stakeholder feedback received.

Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, 153.710)

CMS proposes collection and inclusion of a new risk adjustment indicator QSEHRA as part of the issuer's EDGE Data Submission. Washington state does not collect this information from the enrollee in the *Washington Healthplanfinder* system. These individuals are not required to notify the Exchange of their enrollment in an HRA (either ICHRA or QSEHRA). The Exchange provides enrollees with information regarding how to calculate the affordability of the HRA and how to determine whether they are eligible for tax credits and includes messaging in our application explaining how to adjust tax credits accordingly. The Exchange does not collect from consumers or transmit to issuers information about HRA enrollment. Anecdotally, the Exchange learned that approximately 20 consumers were offered an HRA in 2022 when the consumer or their employer contacted *Washington Healthplanfinder* to seek assistance calculating the accurate amount of APTC to accept or through the appeals process. Due to low uptake of these plan options, Washington does not have any plans to begin collecting this information in the application. The Exchange would not be able to support this CMS reporting requirement for issuers

through an EDI data transmission. Rather than asking issuers to report QSHERA data, Washington strongly encourages HHS to focus on efforts to have issuers submit complete race and ethnicity data in their EDGE data submissions as that will enable CMS and Exchanges to obtain critical demographic information needed to best serve all enrollees.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

The Exchange supports the proposed rule's reinstatement of the ability of navigators and assistors to contact consumers by going door-to-door and through unsolicited communication if approved to do so by their organization. Allowing assistors and navigators to contact individuals proactively about health insurance options using mechanisms that they determine may work best with a given population will help them connect vulnerable populations and hard to reach communities with coverage, which is especially critical over the next few years as more individuals may be expected to transition off Medicaid than ever before.

Documenting Receipt of Consumer Consent (§ 155.220(j))

Washington supports CMS's proposal to require to agents and brokers to document consumer consent and the scope of that consent as it pertains to the enrollment and application process and to retain these records. Additionally, we support requiring agents and brokers to document they reviewed the attestation at the end of an application with the consumer (or their authorized representative) that the information on their application is accurate. The Exchange agrees that this proposal will likely reduce situations where incorrect information on applications prevents the consumer from obtaining coverage, and we think it will be helpful when investigating consumer complaints. The Exchange recommends CMS provide flexibility in how these retention requirements are met.

Failure to File and Reconcile Process (§ 155.305(f))

Washington requests that CMS provide clarification on the intended implementation timeline for their proposal that consumers would lose APTC following 2 years of failure to reconcile. Flexibility for exchanges to pause FTR processing only extends through plan year 2023 and does not appear to align with the IRS proposal to use a 2-year FTR look back period starting with plan year 2025. This proposed change would also require exchanges to store a new FTI data element and to make changes to enrollee communications. Therefore, Washington recommends CMS delay restarting FTR until at least plan year 2025 to align with the IRS's proposed two-year lookback provision.

Extended Resolution Timeline for Data Matching Issues (DMI) (§ 155.315)

The Exchange supports the ability for exchanges to provide consumers with a 60-day extension automatically to resolve an income inconsistency, also known as a data matching issue (DMI), as optional for SBEs. The Exchange appreciates the Administration's efforts to ensure that enrollees do not encounter barriers to coverage. In Washington, the Exchange uses existing authority to provide process extensions to enrollees when documents do not completely resolve inconsistencies in reporting income within the current 95-day time frame. As a result, Washington already has a mechanism in place to assist customers with DMIs.

Washington is concerned that requiring an extended resolution timeline for DMIs that impact APTC eligibility would change eligibility for state subsidy programs which use timelines aligned with federal timelines for DMI resolution. In Washington, the proposed longer timeframes for verifications could increase the risk of enrollees incorrectly receiving state subsidy dollars through a program not currently subject to a state reconciliation mechanism (as there is no state income tax in Washington).

Income Attestation (§ 155.320)

The Exchange supports CMS' proposal to accept an enrollee's attestation of income when IRS income data not available if finalized as optional for SBEs. While the Exchange generally supports the Administration's efforts to ensure that enrollees do not face challenges obtaining coverage, the Exchange encourages CMS to clarify that this expansion would not interfere with the state's ability to use other data sources when verifying income.

Annual Eligibility Redetermination (§ 155.335)

Washington appreciates CMS's various proposals to support consumers enrolling in plans with the most generous coverage that maximizes subsidies while preserving enrollees' access to plan features and providers they value. In finalizing the 2024 Payment Notice, the Exchange encourages CMS to provide state exchanges with flexibility to select from appropriate factors to utilize in plan mapping that best fit the state's needs. Washington strongly supports regulatory flexibility that would allow the Exchange to develop a re-enrollment hierarchy that considers trends from our enrollee population and is tailored to best meet changing consumer needs, product and network availability, and opportunities for federal and state cost assistance.

We support CMS's proposal to re-enroll CSR eligible consumers who are in a bronze plan into a silver plan that has a lower or equivalent premium, but we do not think it should be limited to circumstances where the same product is available in the service area. For example, if an issuer was discontinuing a product in a service area, Washington encourages CMS to ensure that SBEs would have the option to cross-walk CSR-eligible enrollees in a bronze plan to a silver plan with a lower or equivalent premium of the same issuer. The Exchange also suggests CMS consider allowing exchanges to re-enroll consumers into a plan with a slightly higher premium if the consumer would receive more comprehensive coverage resulting in anticipated lower total yearly consumer cost.

Washington would support inclusion of network as an optional consideration for SBEs in the enrollment hierarchy to help enrollees maintain relationships with their providers, and we agree that Network ID is the best mechanism to use. Washington already uses the Network ID as a consideration when cross-walking enrollees from one plan to another.

The Exchange supports CMS's efforts to include estimated out-of-pocket costs when enrollees seek care in the re-enrollment hierarchy. In situations where the issuer leaves the county, the Washington Office of the Insurance Commissioner has implemented a re-enrollment hierarchy that utilizes out-of-pocket costs (calculated as the premium plus deductible) in determining what plan to re-enroll consumers in. The Exchange cautions against using AV as a proxy for out-of-pocket costs because, as a general rule in Washington, we often see that lower AV does not necessarily correlate to lower premium. We think that it would be challenging to factor in balance billing expenses into out-of-pocket costs with any degree of precision as these situations are unpredictable, so the Exchange recommends against including balance

billing costs as a consideration. The Exchange appreciates CMS's proposal to allow exchanges to enroll 73 percent CSR plan variation-eligible enrollees into gold plans if those plans are more affordable. We strongly recommend CMS provides states flexibility in determining what is considered "affordable" for purposes of automatic re-enrollment.

The Exchange supports CMS's proposal to permit Exchanges to enroll consumers into zero-dollar plans if they fail to make a premium payment. Providing the option for SBEs to move delinquent enrollees to a \$0 premium plan may hold some promise to maintain continuity of coverage. Consumers may not pay premiums because they have found other coverage or for other reasons, so this proposal could cause confusion among our consumers and should be approached cautiously. The Exchange recommends CMS provide states flexibility in this area to consider options that may be best suited for their enrollees given the market dynamics at play in each state.

Coverage Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

Washington appreciates the intention behind this proposal. We urge CMS to finalize this proposed change at the option of the Exchange. While Washington supports other exchanges' desire to avoid coverage gaps following mid-month termination through an automated process, Washington already supports and frequently uses a manual process to support our customers who want to avoid coverage gaps following mid-month terminations. Implementation of an automated system to respond to these requests, which we receive fairly infrequently and usually require manual intervention for other reasons, is not feasible or cost-effective for Washington in the foreseeable future.

Washington agrees with CMS that there are improvement opportunities for prevention of coverage gaps for customers, we urge CMS to allow state-based exchanges to address this issue individually to best suit the needs of each state.

Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

Washington appreciates CMS's commitment to ensuring continuity of coverage underpinning this proposal and support SBEs having the explicit authority to modify the involuntary loss of MEC special enrollment period if needed to best respond to this population's needs. However, Washington again urges CMS to maintain this proposed suggestion to be at the option of the Exchange. Loss of Washington Apple Health Medicaid triggers two 60-day SEPs for the customer, one when the customers are notified that they will lose Washington Apple Health Medicaid and one when the customers actually lose Washington Apple Health Medicaid.

While Washington agrees that it is important to ensure that customers do not have a gap in coverage, we have committed significant resources and time to create customer understanding of the 60-day special enrollment period. If a 90-day SEP were to be implemented, it would be a challenge to train account workers regarding a new deadline and may require increased training of staff due to a potential increase in customer escalations because of confusion. There is potential for this to cause confusion in the future, too, for customers who may remember a 90-day SEP and not understand that it was a one-time situation. Additionally, the extended SEP would be difficult to implement with retroactive start dates, and Washington would ask for further clarification and guidance on scenarios where a customer requires a retroactive start date.

Washington suggests broadening the Exceptional Circumstances SEP to include, at state option, loss of Medicaid following the Public Health Emergency unwind. The Exchange would be able to swiftly operationalize such an SEP and better limit potential customer confusion.

Plan Display Error Special Enrollment Periods (§ 155.420 (d))

The Exchange supports both proposals that allow for simplifying the SEP for consumers who are misled in their enrollment decisions by a material error in displays of plan information or facing a situation where their provider is leaving the plan's network mid-year. The Exchange already has implemented similar SEPs based on identified needs in our population. For example, our existing network change SEP encompasses scenarios where customer experiences a mid-year network change that causes a disruption to their pharmacy, medications, physicians, and/or facility. The Exchange also recommends that the plan display error SEP should also include provider directory inaccuracies.

Washington is also supportive of the change to allow anyone (e.g. a carrier) to report a plan display error that may affect a consumer's enrollment. Washington supports CMS technical clarification that an entire household qualifies for an SEP in the case where only one person triggers the qualifying event.

Termination of Exchange Enrollment or Coverage (§ 155.430)

We support CMS's proposal to prohibit FFE carriers from terminating dependent coverage until the end of the plan year in which the dependent turns 26. This requirement will not impact the Exchange since we already have this as a requirement.

Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges (§§155.1500-155.1515)

Washington aligns with CMS's goal of ensuring that our marketplace operate with the utmost integrity and ensure that we are trusted and responsible sources for the proper and accurate distribution of premium tax credits. To meet this standard, the SBMs comply with a variety of both federal and state oversight programs. Washington is open and willing to work with HHS and other federal partners on strategies to ensure the effective and efficient operation of our marketplace, including sharing more data and information with our federal partners. However, we share concerns that the proposed Improper Payment Pre-Testing and Assessment (IPPTA) for State Exchanges will be complex and duplicative, resulting in unnecessary expenditures of federal and state resources.

Before implementation of the IPPTA, we encourage federal partners to first complete and draw lessons from current State Exchange Improper Payment Measurement Program pilots operating in select SBM states. These pilots, currently running in several SBMs should provide early and critical insight into the best means of implementing a future audit program, including feedback on how best to supplement current infrastructure and audit processes already in place across the SBMs. Several states including Washington have already engaged with CMS in good faith to support substantial pre-audit work. The proposed rulemaking continues to define work that substantially duplicates information provided to CMS through SMART and annually required independent programmatic audits.

Standardized Plan Options (§ 156.201)

We support CMS's approach to standardized plan options, which prioritize offering enhanced pre-deductible coverage and using copayments rather than coinsurance to make it easier for consumers to compare plans and to have predictable costs. The Exchange uses some of these same principles in designing its standard plans. Washington encourages CMS to explore ways to lower the deductibles and primary care and specialty copayments in the FFM's silver and gold plan designs as these cost shares are lower in our standardized plans. CMS also should consider setting additional benefits in the silver and gold metals of their standardized plans at a copayment such as laboratory services, x-rays/diagnostic imaging, outpatient facility fees and surgical services to help consumers compare plans and to predict out-of-pocket costs.

Washington appreciates the flexibility given to state-based exchanges to create their own standard plans to meet consumer needs in their respective markets. The Exchange supports CMS requiring carriers to offer only one standard bronze plan (an enhanced bronze), which is Washington's current marketplace requirement, and which we have found to be a sufficient offering at this metal level. We support CMS's efforts to ensure that the prescription drugs are in the cost-sharing tier a consumer would anticipate (e.g., a generic drug has the generic drug cost share) and efforts to monitor that prescription drug cost-sharing tiers are based on clinical evidence and not discriminatory to consumers with certain health conditions.

We agree with CMS's approach that standardized plan designs offer opportunity to reduce consumer barriers to care and promote health equity. The Exchange encourages CMS to consider how AV limits and the AV calculator may make it challenging to implement benefit designs in standard plans that promote access to high-value care. For example, it is challenging to stay within existing AV ranges and offer benefit designs with \$0 cost sharing for services to treat chronic conditions, which vulnerable populations disproportionately face.

Non-Standardized Plan Option Limits (§ 156.202)

The Exchange strongly supports CMS's efforts to limit the number of non-standard plans on the FFE and to reduce the choice overload enrollees face. Washington thinks that a numerical limitation on non-standard plans is a more effective mechanism to reduce choice overload than a meaningful difference standard such as, e.g., requiring plans to have deductibles that differ by at least \$1,000. When plans within the same metal level have large variances in deductibles, the issuer made significantly different plan design choices about those benefit categories where the consumer would pay more costs to stay within the AV range. The consumer is unlikely to understand how these benefit design choices will ultimately impact their out-of-pocket costs when seeking different services. This lack of transparency into where consumer out-of-pocket costs are realized is especially acute if many of the plan benefits are set at a coinsurance.

Washington transitioned smoothly from no limit on non-standard plans in the Exchange to a limit of two bronze, one silver, and two gold non-standard plans per carrier per county within one year, though we recognize that differing market dynamics and numbers of issuers are at play across the FFE state landscape. CMS could consider limiting issuers to one non-standard plan at the silver level to make it easier for CSR-eligible consumers, who are likely to be the most vulnerable QHP consumers, to navigate choice overload challenges and choose the most optimal plan. Washington recommends that CMS consider a stricter limit on the number of non-standard plans in the FFE because the proposed two non-

standard plans per product network type per metal level in each service area may still result in an overwhelming number of plan offerings. In recent surveys conducted by the Exchange, we found that most respondents compared no more than five plans when shopping. Additionally, Washington's experience has been that some issuers have used differing networks to offer multiple standard plans at the same metal level in the same service area, which has resulted in continued choice overload in some counties. Therefore, we recommend that CMS reconsider allowing carriers to offer additional non-standard plans if the network ID differs.

QHP Rate and Benefit Information (§156.210)

The Exchange supports requiring issuers of stand-alone dental plans (SADPs) to use the enrollee's age at the time of policy issuance or renewal as the sole method to calculate an enrollee's age for rating and eligibility purposes for implementation in plan year 2024. This requirement will benefit consumers by reducing confusion. This proposed change would not impact the Exchange since we already include this requirement of our issuers, though we realize that other SBEs may need more time for implementation. The Exchange also fully supports the requirement beginning in 2024 for SADPs to offer guaranteed rates rather than estimated rates. We agree that guaranteed rates for the plan year will result in a better customer experience. In Washington, we have required guaranteed rates for SADP since 2014, and the requirement will not have an impact on the Exchange.

Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

Washington supports CMS's proposal to require accurate plan marketing names and to review plan names during the annual certification process so that misleading plan names are identified and corrected prior to consumers shopping. We think instituting a standard format for plan naming could help consumers when they shop for plans, and Washington requires issuers to follow a naming format for standard plans (known as "Cascade Care" plans). The Exchange adopted the standard plan naming format of [Issuer Name] + Cascade + [Metal Level] when implementing standard plans for plan year 2021, and we found that it simplified comparisons for customers and increased the value standard plans offer to consumers of being able to evaluate like plans on an "apples to apples" basis.

FFE and SBE-FP User Fee Rates for the 2023 Benefit Year (§ 156.50)

The Exchange suggests CMS reconsider their proposal to reduce user fees on the FFE and SBE-FP. Washington's concern is that reducing user fees may undermine the historic enrollment gains for 2023, and we want to maintain healthy marketplaces at the federal and state level. The Exchange does not think reducing user fees will result in the downward pressure on premiums CMS desires because user fees are not driving premium increases. Research has shown that key drivers in rising health care costs are: (1) market consolidation of health care systems increasing the price of health care services¹ and (2) spending on health care waste (e.g., unnecessary tests and procedures)², which burden consumers through rising

¹ Massachusetts Office of the Attorney General, "The Examination of Health Care Cost Trends and Cost Drivers 2022", Mass.Gov, <https://www.mass.gov/lists/reports-on-health-care-cost-trends-and-cost-drivers#2022-report->.

²Health Affairs, "The Role Of Clinical Waste In Excess US Health Spending, " Health Affairs Research Brief, June 9, 2022, <https://www.healthaffairs.org/doi/10.1377/hpb20220506.432025/>.

premiums. We appreciate CMS's attention to affordability and encourage CMS to explore other mechanisms to lower consumer premiums.



COUNCIL FOR AFFORDABLE
HEALTH COVERAGE



January 30, 2023

Submitted electronically

Centers for Medicare & Medicaid Services, Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 2024 Notice of Benefit and Payment Parameters (NBPP)

The Council for Affordable Health Coverage (CAHC) and the Health Benefits Institute (HBI) are pleased to provide joint comments in response to the proposed rule *Patient Protection and Affordable Care Act, Notice of Benefit and Payment Parameters for 2024* (NBPP).

CAHC (www.cahc.net) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. Our members include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers who collectively cover millions of lives in the private market.

The Health Benefits Institute (www.thehealthbenefitsinstitute.org) is a policy organization supported by agents, brokers, insurers, employers, benefit platforms and others seeking to protect the ability of consumers to make their own health care financing choices. We support policies that expand consumer choice and control, promote industry standards, educate consumers on their options, and foster high quality health outcomes through transparency in health care prices, quality, and the financing mechanisms used to pay for care.

Overall, we are concerned with the direction taken by CMS in the NBPP. The proposals included in this rule mark a shift away from providing consumers with appropriate options for the care that best suits them, and increasingly pushes toward a market of “a few sizes fit all”. We urge CMS to continue to appropriately protect consumers while expanding good choices in coverage. Our further comments are outlined below.

NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDERS (§ 156.230 and § 156.235)

CMS proposes to require all qualified health plans (QHPs), Small Business Health Options Program (SHOP) plans, and Standalone Dental Plans (SADPs) to comply with network adequacy and essential community provider (ECP) standards, as well as removing an exception for plans not using a provider network.

First, we are concerned with the concept of applying these standards to all the plans in the market. Specifically, we believe adding in network adequacy standards for standalone dental plans will prove to be problematic. It is not uncommon for these plans to offer robust benefits in out-of-network settings that will allow consumers continued access to their current dental

providers and indeed many consumers likely choose those plans for that reason. We urge you to remove these proposed requirements.

We also find it shocking that CMS would propose to remove the option for a non-network, ACA-compliant benefit plan. It seems anti-consumer and anti-competitive at best, as well as short sighted. Provider networks were originally developed to help insurers receive favorable payment arrangements from providers, and similar to other programs, traded lower reimbursement rates for an increased volume of patients. These arrangements now have a variety of new requirements including rules surrounding the delivery of medical care sometimes – but certainly not always – to the benefit of the patient. It is also important to note that this comes at a time in which multi-state plans are collapsing and some state exchanges are dominated by regional health systems without a national reach.

Even more troubling is that this proposal essentially locks in the relationships with the insurers in the exchange, forestalling new health insurance competitors operating on different models. At a time where there is the increasing availability of pricing data, CMS is making it impossible for carriers to develop new insurance models to empower consumers to make their own choices in medical care rather than relying on the insurer's network.

We urge CMS to reverse course on the issue of networks, and to develop a pathway for non-network plans to meet ACA standards.

STANDARDIZED PLAN OPTIONS (§ 156.201 and 156.230)

CMS proposes to require all QHP issuers to offer standardized plans for every network type and at each metal level in every area an issuer offers a non-standardized plan. At the same time, the proposal is to limit the amount of non-standardized plan options issuers may offer for each plan type and metal level. This is by definition limiting consumer choice, and severely impacts the ability of insurers to provide specialized products to meet the needs of consumers. CMS, by its own admission, knows that these changes will eliminate a significant number of offerings from the marketplace, and result in an estimated 2.72 million enrollees' plans being discontinued. According to Kaiser Family Foundation¹, about 14.5 million enrollees signed up for health insurance through the marketplaces last year. So, CMS is proposing to cause 20% of consumers to have to choose a different plan than the one they have, in the name of making the enrollment process "simpler". This is a backwards proposition and should be abandoned.

Further, as a result of CMS's automated plan selection process, these changes will result in chaos in the marketplace. Consumers whose plans disappeared as an option may end up in plans that do not meet their needs as the CMS crosswalk matches them with a different plan. We again suggest that this proposal be reworked, to align with the goal of avoiding consumer confusion.

¹ <https://www.kff.org/health-reform/state-indicator/total-marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

“STREAMLINING CHOICE” (§ 156.298)

CMS also proposes to apply an even more stringent standard to determine whether plans are “meaningfully different” from one another. These proposals are entirely wrong-headed, and we firmly oppose them. Enabling a consumer to choose the most suitable from several different plans is the job of the exchange itself. A user-friendly exchange tool would assist consumers by taking account of their needs for their coverage and comparing plans in a way that makes a decision simpler. Instead, CMS is attempting to force insurers to pay the price of exchanges that do not do their job well. We do not believe consumers would be best served by limiting their choices in plan options, and we cannot support this proposal and urge it be reconsidered.

FFM AND SBM-FP USER FEE RATES FOR THE 2024 BENEFIT YEAR (§ 155.160 and § 155.200)

We are pleased that the proposed rule addresses the high user fees by lowering them to 2.5% for the FFM and 2.0% for the SBM-FP. Such a reduction is in line with past HBI comments – high user fees only drive up premiums. We urge CMS to continue further reductions to keeping easing the burden of higher than necessary user fees.

ESTABLISHING A TIMELINESS STANDARD FOR NOTICES OF PAYMENT DELINQUENCY (§ 156.270(f))

CMS proposes to require issuers to send a notice of payment delinquency within a specified timeframe and seeks comment on what timeframe might be appropriate. We suggest that CMS abandon this issue entirely. These rules are already set and are being enforced at the state level. Setting a new federal standard will be problematic, confusing, and difficult to enforce.

REQUIREMENTS FOR AGENTS, BROKERS, AND WEB-BROKERS (§ 155.220(j)(2)(iii)(A)(2) and § 155.220(j))

The rule contains proposals to give HHS additional time to review information regarding agents, brokers, and web-brokers when they have had their marketplace agreements suspended or terminated entirely. HHS proposes to have 15 extra days (45 days total) and 30 extra days (60 days total) for each scenario, respectively. While we understand the need to be thorough with this work, the proposed time periods are excessively lengthy, and would likely pose issues to the respective agents and brokers, especially during a time of the year such as open enrollment. We suggest HHS reconsider to balance the needs of agents and brokers as well as the protection of the consumers they serve.

The other new proposal in the rule is to require agents and brokers to retain consumer eligibility information and receipt of consent documentation for a minimum of ten years and produce it upon request. Given that current records requirements are generally set at five years, we believe the proposed amount of time is excessive and burdensome. Such a requirement would double the amount of documents that an agent or broker would have to keep while providing no value and no additional layers of protection. While the goal of the proposal is admirable – to protect consumers and find bad actors – it is wrongheaded and instead creates a significant burden for the vast majority of agents and brokers who are acting legally and with the best interests of the consumer at heart. We suggest CMS revise their course of action to target bad actors specifically.

Thank you again for providing an opportunity to comment on the NBPP. Please do not hesitate to reach out if you have further questions at joel.white@cahc.net or jpwieske@thehealthbenefitsinstitute.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Joel White", with a stylized, cursive script.

Joel White
President, CAHC

A handwritten signature in black ink, appearing to read "J.P. Wieske", with a stylized, cursive script.

J.P. Wieske
Executive Director, HBI

January 30, 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Notice of Benefit and Payment Parameters for 2024 [CMS-9899-P]

Dear Administrator Brooks-LaSure:

On behalf of the 159,000 members of the American Dental Association (ADA) and the 10,800 members of the American Academy of Pediatric Dentistry (AAPD), we are writing to you in regard to the proposed rule, CMS-9899-P, the Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2024. The ADA and AAPD appreciate the Centers for Medicare and Medicaid Services' (CMS) and the Department of Health and Human Services' (HHS) efforts to provide quality, affordable coverage to consumers while minimizing administrative burden and advancing health equity.

As organizations dedicated to advancing the oral health of the public, we appreciate the opportunity to share our thoughts with CMS on how these goals can best be achieved in dentistry.

A Uniform Age-Rating And Eligibility Methodology For Stand Alone Dental Plans

The ADA and AAPD support proposing requiring Stand Alone Dental Plan (SADP) issuers to use the age on the effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes beginning in 2024. Though it's apparent most issuers already use this approach, setting one standard for all brings more certainty and less confusion when comparing plans for consumers regardless of which SADP they may choose.

Guaranteed Rates For SADPs

Allowing SADP issuers to offer either guaranteed or estimated rates no longer seems an appropriate choice at this point. Instead, proposing to bring clarity with only the submission of guaranteed rates will allow for accurate advance premium tax credits (APTCs) of the pediatric dental essential health benefit (EHB) portion of premiums. Additionally, guaranteed rates add transparency and clarity for consumers. We support this proposal and its effort to help those consumers who may qualify for APTCs.

Network Adequacy

CMS proposes to revise network adequacy standards starting in 2024 by eliminating an exception for plans that do not maintain a provider network and instead require all plans, including SADPs, to comply with network adequacy requirements. As noted in the proposed rule, *"in PY [plan year] 2022, only 8 of the 672 SADPs certified as QHPs [qualified health plans] on the FFEs [federally-facilitated exchanges] were plans that do not use a provider network"*. The proposed network adequacy requirement for SADPs would aptly improve consumer choice and access to care. Allowing for a new narrow exemption would not allow for SADPs to continue growing their plans, even where provider networks are currently thin.

Plan Marketing Transparency

CMS proposes to require fair marketing practices of QHPs, such that correct information is included, material facts are not omitted, and content is not misleading. Dental plan marketing has been a significant concern in Medicare Advantage plans in recent years, and this is a proactive approach to preventing similar, potentially deceptive marketing of SADPs. We do believe there should be a standard marketing format used by plans; one that is simple (perhaps one-page), captures important cost considerations for consumers (e.g., coinsurance obligations), and provides direction to consumers on how to find participating providers.

The ADA and AAPD look forward to continuing to work with CMS and we would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments. Please contact Mr. David Linn at the ADA at (202) 789-5170 and linnd@ada.org or Dr. Chelsea Fosse at the AAPD at (312) 337-2169 and cfosse@aapd.org to facilitate further discussion.

Sincerely,



George R. Shepley, D.D.S.
ADA President



Amr M. Moursi, D.D.S., PhD
AAPD President

GRS:AMM:dl



January 30, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9899-P
Mail Stop C4-26-05
Baltimore, MD 21244

Re: HHS Notice of Benefit and Payment Parameters for 2024 Proposed Rule

Submitted Electronically: www.regulations.gov

Dear Administrator Brooks-LaSure,

UnitedHealthcare (UHC) is pleased to respond to the Centers for Medicare and Medicaid Services (CMS) *Notice of Benefit and Payment Parameters for 2024* proposed rule. The proposed rule was published in the Federal Register on December 21, 2022 (87 FR 78206) and establishes standards for health insurance coverage sold in individual and group markets (including Exchanges) for the 2024 plan year.

UHC is dedicated to helping people live healthier lives and making the health system work better for everyone by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. In the United States, UHC offers the full spectrum of health benefit programs for individuals, employers, and Medicare and Medicaid beneficiaries, and contracts directly with more than 1.3 million physicians and care professionals, and 6,500 hospitals and other care facilities nationwide.

We appreciate the opportunity to provide recommendations on providing quality, affordable coverage to consumers. We support CMS' proposal to increase access to affordable coverage via a Special Enrollment Period (SEP) for consumers losing Medicaid or the Children's Health Insurance Program (CHIP) coverage, as well as the "Unwinding SEP" recently announced by CMS that will begin March 31, 2023. We encourage CMS to apply the Unwinding SEP to not only Exchange plans, but also plans offering individual off-Exchange or group coverage to ensure as many people get connected to coverage as possible. On the other hand, we have concerns about CMS' proposal to hinder consumer choice by limiting the number of non-standardized Exchange plan options that insurers can offer. We have the following comments and recommendations on these proposals:

Special Enrollment Period for Loss of Medicaid and CHIP

CMS proposes that, beginning January 1, 2024, Exchanges have the option to implement a new SEP for consumers losing Medicaid or CHIP coverage that is also considered minimum essential coverage, allowing consumers up to 90 days - rather than the current 60 days - after loss of their Medicaid or CHIP coverage to select an Exchange plan. Uninsured individuals can face barriers to enrollment, such as administrative hurdles, and we agree that this additional time to enroll will mitigate

the risk of coverage gaps and ensure that qualifying individuals have time to transition from Medicaid or CHIP coverage to Exchange coverage.

CMS also recently announced an “Unwinding SEP,” set to begin March 31, 2023 and lasting through July 31, 2024. CMS is concerned that once Medicaid Maintenance of Effort (MOE) requirements end in April 2023 and Medicaid redeterminations start, Medicaid and CHIP beneficiaries may face exceptional challenges when transitioning to other forms of coverage, such as Exchange coverage. Exchange-eligible consumers who submit a new application or update an existing application between March 31, 2023 and July 31, 2024, and attest to a last date of Medicaid or CHIP coverage within the same time period, are eligible for an Unwinding SEP.

We applaud the decision of CMS to create the Unwinding SEP and encourage CMS to extend the SEP to individual off-Exchange plans and the group market. Experts estimate that the end of the PHE-related MOE requirement and subsequent Medicaid redeterminations could result in up to 14.2 million Medicaid enrollees losing coverage.¹ In the proposed rule, CMS cites to Medicaid and CHIP Payment and Access Commission data demonstrating that most consumers losing Medicaid or CHIP may not transition to Exchange coverage in a timely manner. Providing consumers the opportunity to enroll in Exchange plans as well as individual off-Exchange plans and group coverage will help facilitate Medicaid redeterminations by mitigating coverage gaps in 2023 and ensuring that Medicaid enrollees losing coverage have the opportunity to transition to other coverage.

Limiting Non-Standardized Plans

CMS proposes to limit the number of non-standardized plan options that an insurer can offer on Federally Facilitated Exchanges and State-Based Exchanges using HealthCare.gov to two non-standardized plan options per product network type and metal level. UHC recognizes and appreciates the concerns CMS and some stakeholders have related to plan choice overload. However, we do not believe that restricting non-standardized plans is the appropriate approach to solve this issue. This proposal, if finalized, would be disruptive and negatively impact the ability of consumers to find the plan that best fits their needs.

Consumers can manage and even benefit from a market that allows for robust choice and competition. In Medicare for example, seniors in 2022 had a choice of 23 stand-alone Part D plans and 31 Medicare Advantage (MA) plans offering Part D, on average.² Seniors have a wide range of choices – plans with lower or no deductibles, plans with copay or coinsurance models, and plans with different tiering structures. Premiums in Part D remain affordable – actually decreasing in 2023 from 2022.³ Similarly, in MA seniors have a choice of 43 plans on average in 2023, with wide ranging variation to meet their needs. This level of choice also benefits seniors’ pocketbooks, with an MA premium averaging just \$18 a month in 2023. In 2023, eight new organizations entered the MA market.⁴ Exchange enrollees can benefit from more, not less choice, as Medicare seniors have.

In the regulatory impact analysis of the proposed rule, CMS estimates that approximately 2.72 million (or 26.6 percent) of enrollees would have their current plan discontinued if the agency finalized this proposal. Many enrollees will lose a plan that that they are satisfied with and may be reenrolled into plans that do not fit their needs. Data demonstrates that three-fourths of Exchange enrollees are satisfied with their plan coverage.⁵ Further, during the Exchange open enrollment period, only about

¹ <https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/>

² [Medicare Part D: A First Look at Medicare Prescription Drug Plans in 2022 | KFF](#)

³ [CMS Releases 2023 Projected Medicare Basic Part D Average Premium | CMS](#)

⁴ [Medicare Advantage 2023 Spotlight: First Look | KFF](#)

⁵ <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>

20 percent of returning enrollees switch Exchange plans if they have the choice to stay with their Exchange plan from the previous year.⁶

This proposal also limits plan design innovation and prevents issuers from creating plans that meet the widely varying needs of all consumers in a market. During open enrollment for plan year 2023, UHC found that new enrollments were fairly evenly split across our spectrum of Qualified Health Plan (QHP) offerings, with some consumers choosing plans that are narrowly tailored to the essential health benefits package and others selecting more robust coverage including additional benefits. This experience suggests that consumers value the ability to choose a plan that best works for them. If CMS' proposal is finalized, consumers will lose access to certain of the differentiated plan offerings that they are seeking from the market, such as plans including adult dental and vision benefits and those that are centered around access to virtual care.

Instead of limiting plans, if CMS is concerned about consumer confusion, CMS could enhance the consumer experience by creating tools that help consumers identify what features in a plan are important to them and allow for filtering and identification of preferred plans. Eliminating plans is not the solution to creating a better consumer shopping and selection experience. We believe the agency should reconsider this proposal given the expected disruption it would have to a quarter of enrollees and work with plans to develop alternative, less disruptive policies in the future. Additionally, we request that CMS issue a final rule in a timely manner – preferably prior to the opening of the QHP application window in April. In order to properly implement any requirements for the 2024 plan year, issuers will need adequate time to file plans, and states and CMS will need adequate time to review plan offerings.

Attached are additional technical comments and recommendations on the *Notice of Benefit and Payment Parameters for 2024* proposed rule.

We appreciate the opportunity to comment on the proposed rule and look forward to working with CMS to provide quality, affordable coverage that best meets consumer needs. Thank you for your thoughtful consideration of our comments. Please do not hesitate to contact me if you have any questions.

Sincerely,



Philip Kaufman
Chief Growth Officer
UnitedHealthcare

⁶ <https://www.healthaffairs.org/content/forefront/rethinking-marketplace-automatic-reenrollment-algorithms>

UnitedHealthcare Technical Comments
2024 Notice of Benefit and Payment Parameters Proposed Rule

UnitedHealthcare (UHC) is submitting the following technical comments to the Centers for Medicare & Medicaid Services (CMS) regarding the Proposed Rule on the Notice of Benefit and Payment Parameters for 2024 (the “Proposed Rule”). The Proposed Rule was published in the Federal Register on December 21, 2022 (87 FR 78206) and establishes standards for health insurance coverage sold in the individual and group markets, including Exchanges, for the 2024 plan year.

Placement of Generic and Brand Name Drugs

CMS proposes to require issuers of standardized plan options to place all covered generic drugs in the standardized plan options’ generic drug cost-sharing tier or the specialty drug tier; and place brand name drugs in either the standardized plan options’ preferred brand or non-preferred brand tiers, or specialty drug tier.

Response: UHC encourages CMS to allow continued flexibility to place brand and generic medications across multiple tiers on the formulary based on their relative clinical and financial value. There are numerous examples of high-cost generic medications with available lower-cost, clinically similar alternatives. There are also brand-name medications that may offer clinical and financial value that supports tiering lower than the preferred brand tier. Using this approach to tier medications is common in the industry, including in the commercial market and Medicare.

Limiting Non-Standardized Plans to Two Per Product Network Type and Metal Level

CMS proposes to limit the number of non-standardized plan options that QHP issuers can offer through Exchanges on the Federal (healthcare.gov) platform (including State Based Marketplaces on the Federal Platform) to two per product network type and metal level.

Response: UHC recognizes and appreciates the concerns CMS and some stakeholders have expressed related to plan choice overload. However, we do not believe that restricting the number of non-standardized plans to two is the appropriate approach to address this issue. This approach may have the opposite effect since it limits plan design innovation and prevents issuers from creating plans that meet the widely varying needs of all consumers in a market. We point out that CMS used PY2022 data to estimate that, if adopted, this proposal would result in 2.72 million enrollees – more than one in four – losing their current plan. However, CMS’ own data on PY2023 open enrollments confirms that, as of January 11, 2023, nearly 11.9 million consumers have enrolled in 2023 coverage using healthcare.gov, suggesting that perhaps an additional 450,000 enrollees, or approximately 3.17 million in total, will lose the plan they select for 2023 if this proposal is finalized.⁷

The solution to plan overload for several million consumers with widely varying healthcare, financial and personal needs and preferences is not to eliminate plan options based on arbitrary, “one size fits all” criteria predetermined by CMS. To the contrary, CMS should allow issuers to offer the plan designs they feel meet broader market needs while giving each consumer access to better, more robust tools so they can search for, identify, view, and select from a subset of plans that more appropriately meet their particular health care, financial, and personal needs and preferences.

If, however, CMS chooses to limit plan offerings, we believe implementation of CMS’ alternative option of a meaningful difference standard would (of the proposals under consideration) be better positioned to achieve the desired outcome of reducing plan offerings while supporting ease of consumer choice by requiring plans to be more distinctly different. If adopted, the meaningful difference standard should consider differences in cost share (e.g., the proposed \$1,000 difference in

⁷ [Marketplace 2023 Open Enrollment Period Report: National Snapshot #3](#), CMS, accessed 1/13/2023.

deductible) in plan features such as provider network or coverage of benefits beyond EHB that would create a truly different product by CMS' definition. This approach maintains an issuer's ability to offer different products such as plans with or without adult dental or vision benefits and network variations (broad or lower-premium narrow networks) that are desired by consumers in the market while still limiting the plan offerings by requiring member cost sharing or plan features to be noticeably different.

In the event that CMS does finalize its proposal to limit non-standardized plans to two, UHC seeks clarification as to how CMS intends to enforce the two-plan limit in a Federally Facilitated Exchange state that requires issuers to offer a state-mandated plan design that may differ from the federal standardized plan. UHC reiterates its general opposition to restricting non-standardized plan designs to two plans, but should CMS finalize such a policy, we encourage the agency to clarify and codify that state-mandated plan designs are excluded from the two-plan limit imposed by CMS. Also, regardless of which policy CMS finalizes, the agency should provide stakeholders with guidance regarding how it will evaluate compliance. For example, CMS should clarify whether this evaluation will be done at the HIOS Product ID level or some other level.

Income Data Matching Issues

CMS proposes that it would accept a household's income attestation when an Exchange requests tax return data from the Internal Revenue Service (IRS) but such data is not available.

Response: UHC supports this proposed change and believes that the lack of available IRS data should not prevent consumers from obtaining important health care coverage when they need it.

Allowing Door to Door Enrollment by Navigators and Other Assistors

CMS proposes to allow assistors to conduct door-to-door enrollment to increase consumer engagement and advance health equity.

Response: UHC supports this proposed change and believes it gives more consumers access to affordable coverage and advance efforts to improve health equity. This approach will increase opportunities for consumers – especially those who face barriers such as health disparities or lack of access to transportation – to enroll in coverage.

HHS-Operated Risk Adjustment Program

Use of EDGE Data

CMS proposes that, for the 2024 benefit year RA models, it would use the 2018, 2019, and 2020 enrollee-level EDGE data for model recalibration, with one exception. For the adult models' age-sex coefficients, CMS proposes to blend only the 2018 and 2019 enrollee-level EDGE data and to exclude the 2020 enrollee-level EDGE.

Response: UHC supports this approach. As noted in prior comments to CMS, we believe this dataset is a more accurate reflection of the market subject to risk adjustment.

Request for Information: Payment HCC for Gender Dysphoria

CMS requests information on adding a payment HCC for gender dysphoria to the HHS-operated risk adjustment models for future benefit years.

Response: If CMS adopts this proposal, UHC requests that, in order to ensure the HHS-operated risk adjustment model remains actuarially sound, CMS follow the same precepts and methodology as any other condition in its evaluation of gender dysphoria. We have concerns that, without such consideration, current inconsistencies in benefit coverage and costs could make the inclusion of gender dysphoria to the HHS-operated risk adjustment model challenging. UHC urges CMS to

consider its original risk adjustment principles (notably principles 2 and 3 regarding predictive accuracy and availability of adequate sample data) when making the determination as to the appropriateness of this and any other HCC adjustments.

Collecting the QSEHRA data element

CMS proposes that, beginning with the 2023 benefit year, it would collect and extract from issuers' EDGE servers a new data element, a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator, and extract plan ID and rating area data elements issuers have submitted to their EDGE servers from certain benefit years prior to the 2021 benefit year.

Response: UHC opposes adopting this change at this time. Health issuers continue to be engaged in several significant implementation efforts related to the Consolidated Appropriations Act of 2021, interoperability and transparency rulemaking, and other projects. We note that guidance on those major initiatives is, in some cases, still evolving and unclear. Adding new operational and health information technology requirements increases these challenges, especially if requirements are finalized in Spring 2023 for implementation by September 2023. We ask that any new data collection and extraction requirements be delayed to 2025 or, alternatively, at a minimum, that CMS exercises its enforcement discretion to work with issuers that are making a good-faith effort to implement the new requirements.

UHC also urges CMS to publish guidance as soon as possible to clarify the detailed requirements necessary for issuers to incorporate the five additional fields which CMS finalized in the 2023 Notice of Benefit and Payment Parameters in May 2022. Without such guidance from CMS, submissions are likely to utilize the default value for fields specific to ICHRA and QSEHRA.

UHC reiterates our comments from prior years and below that this use of this data should be restricted to its intended use, and not shared for other purposes.

Extracting Plan ID and Rating Area

CMS proposes to extract the plan ID and rating area data elements from the 2017-2020 benefit year data submissions that issuers have already made accessible to HHS.

Response: As we have stated in prior years, UHC opposes the use of EDGE data for non-risk adjustment purposes. We believe this data should only be used for risk adjustment and the actuarial value calculator.

Proposed Repeal of States' Ability to Request Reduction in Risk Adjustment State Transfer

CMS proposes to repeal the ability of all states, including those prior participant states that had previously submitted a state flexibility request, to request a reduction in RA state transfers starting with the 2025 benefit year.

Response: UHC supports this proposal and we also urge CMS to deny Alabama's request for 2024. As we have stated in prior years, the risk adjustment program is working as intended by removing incentives for issuers to target only healthier populations and reducing premium disparities between issuers with lower actuarial risks (i.e., healthier populations) and those with higher actuarial risks (i.e., sicker populations). Therefore, such state requests are unnecessary even today, but if CMS does approve Alabama's request for 2024, we urge it to finalize the proposal such that no state, including Alabama, should be permitted to submit a request starting with 2025.

Discontinuation of Life Long Permanent Condition

CMS proposes to remove the Life Long Permanent Condition (LLPC) list from Risk Adjustment Data Valuation (RADV) protocols.

Response: UHC supports CMS's effort to ensure that the requirements for claims submissions to EDGE and RADV protocols are aligned. The current misalignment creates an ability for potential misuse of EDGE submissions which the RADV program would not be able to identify.

Changes to the Materiality Threshold

CMS proposes to change the materiality threshold for random and targeted sampling from \$15 million in total annual premiums Statewide to 30,000 total billable member months Statewide.

Response: UHC supports this proposal. We also request that CMS explore how to balance the count of the random Issuer selection each year within a parent company. The regulation guidance of auditing once every three years, including the option to re-audit as CMS deems necessary, is reasonable. However, in practice, CMS selections have not reflected a balanced volume within a RADV program year. Historically speaking, random Issuer selections have produced a low one-third count of random issuer selections in some years and high counts in other years. For operational and financial planning purposes, we suggest that CMS consider making its random selections more consistent in volume each year within a Parent company grouping.

Shortening the Window to Confirm or Dispute Second Validation Audit Findings

CMS proposes to shorten the window to confirm or dispute the findings of the Second Validation Audit to within 15 calendar days of the notification by HHS beginning with the 2022 benefit year.

Response: UHC supports this proposal and believes that the shorter timeframe should be sufficient based on historical experience. UHC also points out that Risk Adjustment Transfer reporting, which includes RADV financial adjustments, is time sensitive because it is required for MLR filings. Therefore, we request that CMS publish this reporting annually no later than June 30.

Requiring Agents, Brokers and Web-Brokers to Document Consumer Consent

CMS proposes to require agents, brokers, and web-brokers to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer prior to application submission. CMS also proposes to require agents, brokers, and web-brokers to document the receipt of consent from the consumers they are assisting.

Response: UHC generally supports the proposal but urges CMS to clarify what it considers to constitute consent and that this be standardized in a way to ensure that all agents, brokers, and web-brokers are using a consistent approach. Currently enrollment is done electronically or by telephone, even when consumers may meet with their agent, broker or web-broker in person. The FFM and other Enhanced Direct Enrollment paths currently include a simple checkbox for agents and brokers to attest that consumers have provided their consent and, prior to application submission, reviewed the eligibility application information and confirmed that such information is accurate. While this approach is convenient, it does little to alleviate concerns that might arise if there is a dispute about whether a consumer actually attested to such information or provided consent. We point out that many consumers, including those who may work with an agent, broker or web-broker in person or over the phone, may not even know who their agent of record is, let alone whether that agent has made any changes to application materials or the submission itself either during or after submission.

UHC believes that most agents, brokers, and web-brokers will make a good-faith effort to truthfully attest and comply with these consent requirements, and we believe that CMS should work with those who are doing so while taking strong enforcement actions against those who do not. If CMS finalizes new requirements related to what is involved in capturing and documenting a consumer's agreement and consent, UHC encourages CMS to consider delaying implementation to the 2025 plan year so that stakeholders can make appropriate changes to their processes and technology. Alternatively,

UHC recommends that CMS consider exercising its enforcement discretion to offer a temporary safe harbor for agents, brokers, and web-brokers who are making a good-faith effort to implement these changes. UHC also encourages CMS to clarify the applicable civil monetary penalties or other consequences agents, brokers, web-brokers or others may face for violating these provisions, since doing so may deter unscrupulous activity.

Timing of the Release of Future Notice of Benefit and Payment Parameter Rules

In order to give states, Exchanges, issuers, and other stakeholders sufficient time to prepare for the changes necessary to implement annual updates under the Notice of Benefit and Payment Parameters (NBPP), UHC urges CMS to consider an earlier release schedule. UHC is concerned about the limited time stakeholders have to implement changes – some of which require substantial changes to processes, technology, marketing materials, and more – when they are finalized so close to, or even during, the federal and state filing season each Spring.

When CMS recently codified its decision to carve out of NBPP the annual adjustments to limits on cost-sharing, it did so in part to give states and issuers more time to prepare for these changes. UHC appreciates that CMS now publishes those updates each January to allow stakeholders a full year before the benefit year to prepare. We point out, however, that many changes that remain part of NBPP – this year and generally – require significantly more time and resources to implement, making it critical that CMS finalize those changes as early in the year preceding the benefit year as practical.

UHC urges CMS to publish the annual draft NBPP in September or October, which allows for public comments and an expeditious review so that the final NBPP can be published in December or January.

January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024—AHIP Comments

Dear Administrator Brooks-LaSure:

On behalf of AHIP, thank you for the opportunity to offer comments in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2024 (“Payment Notice”) which was published in the *Federal Register* on December 21, 2022 (CMS-9899-P).¹

Tens of millions of Americans now enjoy the improved health and financial stability of health insurance they choose through the ACA Marketplaces. The successful public-private partnership between HHS, Congress, and health insurance providers has led to a very stable market and record-breaking enrollment year-after-year. For 2023, more than 16.3 million Americans selected a Marketplace plan – including a 21% increase of Americans who purchased from the Marketplace for the first time. We applaud the Administration’s efforts to achieve these enrollment gains. The continuation of the enhanced advance premium tax credits (APTC) and other expanded subsidies, robust plan choices, and increased education and outreach have led to this historic moment. We look forward to a strong continued public-private partnership to promote affordability, access, choice, and equity, along with strong patient protections.

Marketplace consumers had a choice of between 6 and 7 Qualified Health Plan (QHP) issuers on average for 2023, providing robust competition that offered hardworking

¹ AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. We believe that when people get covered and get and stay healthy, we all do better. The best way to do that is to expand on the market-based solutions and public-private partnerships that are proven successes.

American families more choices, better quality, and lower costs. We look forward to promoting policies that provide Americans with even more high-quality, affordable coverage choices.

We appreciate HHS' proposals that promote access and mitigate coverage gaps, such as the proposed changes to Special Enrollment Periods (SEP). We are also encouraged by HHS' request for information about including gender dysphoria in the risk adjustment model and look forward to additional dialogue about ways to reduce barriers to care and enrollment for LGBTQ+ individuals.

However, we are concerned that some proposed policies may drastically disrupt the Marketplaces at a time of great change and uncertainty. States will soon be redetermining whether more than a quarter of the U.S. population is still eligible for Medicaid coverage. Of the more than 90 million Medicaid enrollees who are to be redetermined, approximately 10 million will be eligible for other coverage, including Marketplace coverage. As such, the Marketplaces need to be prepared for a massive influx of enrollees over the coming months. Major policy changes, such as the proposals to limit non-standardized plans, amend the reenrollment hierarchy, and further changes to standardized plans could cause severe disruption for both consumers and health insurance providers. As such, we urge caution against implementing significant policy changes that could overburden the health care system and negatively impact affordability, competition, and consumer choice.

Our comments prioritize recommendations that would achieve similar goals while minimizing disruption for Americans. Those recommendations address:

- **Non-Standardized Plan Option Limits:** AHIP shares HHS' goal of ensuring Americans can easily find affordable, high-quality coverage that best meets their individual and family preferences. We understand the Department's concern that people in some markets have a considerable number of plan choices that can feel overwhelming. However, Americans strongly and consistently want choices for their coverage and care, and we strongly oppose HHS' proposal to limit the number of non-standardized plan options to two non-standardized plan options per product network type and metal level.

Health insurance providers offer a variety of plan designs and benefits to address consumers' varying and unique health needs. Limiting these options would eliminate choice for enrollees that have varying preferences, including value access to high-value networks, broad access to providers, specific plans that contract with particular health systems or provider groups, cost-sharing and premium level preferences, health savings account (HSA) eligibility, ability to add supplemental benefits or other plan offerings, and much more. Furthermore, limiting plan offerings during the unwinding of the

COVID-19 Public Health Emergency and forthcoming Medicaid redeterminations would drastically disrupt the Marketplace.

Instead, we recommend HHS adopt the alternative proposal to implement a meaningful difference standard to make it simpler and easier to compare coverage. We further recommend HHS refine the proposed standard to reduce the deductible differential to \$500 and incorporate stakeholder feedback and other factors that consumers value. If HHS proceeds with any changes to limit non-standardized plan options or reinstate meaningful difference standards, we recommend that HHS compare plans at the network ID level, not by network type.

- **Network Adequacy:** Health insurance providers worked in partnership with CMS to implement new network adequacy standards over the past year. To improve the network adequacy review process for plan years 2024 and beyond, we recommend HHS establish clear timelines for the network adequacy review process, including a deadline to notify issuers whether their plan has been approved under the process, and improve the exceptions process to allow additional flexibility in exceptional circumstances.

We further recommend HHS allow an additional year for issuers and regulators to refine the new network adequacy review process during plan year 2024 QHP certification prior to implementing appointment wait time standards. Delaying appointment wait time standards would allow HHS adequate time to conduct issuer testing and establish a reasonable framework for assessing appointment availability. It would also provide issuers time to prepare self-compliance review processes and operationalize data collection.

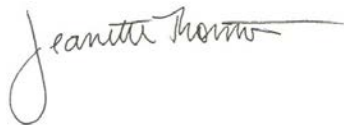
In addition, we recommend CMS adopt a voluntary telehealth credit and that CMS work with the National Association of Insurance Commissioners (NAIC) and other stakeholders to share ideas and gain feedback. AHIP also supports HHS' proposal to implement a limited exception for standalone dental plan (SADP) issuers where it would be "prohibitively difficult" to establish a network of dental providers.

- **Standardized Plan Options:** AHIP appreciates that HHS chose to make limited modifications to the design of standardized plans for the 2024 plan year, further promoting stability in the Marketplace. However, AHIP is concerned the proposed change to classify prescription drug tiers for standardized plans could have severe consequences. These changes limit scenarios that enable issuers to place high-priced brand drugs onto a lower-cost tier, eliminating potential cost-savings and raising prices for consumers. We urge HHS to continue deferring to issuers to establish prescription drug tiers that effectively balance cost, access, and quality for enrollees.

- **Essential Community Providers (ECP):** HHS proposes to require QHPs to contract with at least 35% of both available Federally Qualified Health Centers (FQHC) and Family Planning Providers and to add Rural Emergency Hospitals (REH) as a provider category under Other ECP Providers. AHIP believes patients should have access to a robust network of providers to support their changing health care needs, including ECPs. However, we caution against implementing a threshold for specific ECP categories. Strict ECP thresholds fail to account for provider and population distribution and other factors and could make it more difficult for issuers to meet required ECP provider contracting requirements. Furthermore, we recommend HHS delay adding REH as a separate category under Other ECP Providers until plan year 2025 as states, hospitals, providers, and other stakeholders are still in the process of implementing new REH standards based on recent guidance.
- **Annual Eligibility Redetermination:** AHIP shares HHS' goal of ensuring people have the necessary tools to choose the plan that best fits their needs. However, we oppose HHS' proposal to modify the reenrollment hierarchy to automatically reenroll people into a plan they did not actively select in situations when their current QHP is available, as well as when their current QHP is no longer available. Americans actively choose their health plan for several reasons, including but not limited to net premium, provider network, and out-of-pocket costs. This proposal assumes consumers always value income-based cost-sharing reductions (CSR) and net premium above all other factors – and while this may be true for some, it is incorrect to assume this applies to everyone. Issuers are also concerned about how this policy will affect Guaranteed Renewability of Coverage Requirements, specifically those regarding issuer renewal notices. As an alternative, we encourage HHS to improve consumer decision support tools and education around silver plans.

We provide detailed comments on these and other provisions of the proposed rule in the Attachment. We appreciate the opportunity to provide comments and look forward to continued partnership with HHS to ensure affordable, quality, equitable coverage and care is accessible to everyone.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jeanette Thornton", with a long horizontal flourish extending to the right.

Jeanette Thornton
Executive Vice President, Policy and Strategy

Attachment
AHIP Comments on 2024 Proposed Notice of Benefit and Payment Parameters

AHIP's detailed comments on the proposed 2024 Payment Notice are organized by the following topics:

- I. Non-Standardized Plan Option Limits
- II. Standardized Plan Options
- III. Plans that Do Not Use a Provider Network: Network Adequacy and Essential Community Providers (ECP)
- IV. Essential Community Providers
- V. Annual Eligibility Redetermination
- VI. Risk Adjustment and Risk Adjustment Data Validation (RADV) (Part 153)
- VII. Exchange Standards (Part 155)
- VIII. Issuer Standards (Part 156)

I. Non-Standardized Plan Option Limits (§ 156.202)

AHIP strongly encourages HHS not to limit non-standardized plan options for the 2024 plan year. We strongly oppose adopting blunt instruments like limiting non-standardized plans that would harm competition, disrupt coverage for existing enrollees, and stifle value-based insurance designs. However, if HHS proceeds with a proposal to limit the number of non-standardized plans on the Exchange, AHIP has several recommendations to ensure consumers continue to have robust coverage options that meet their individual health care needs.

AHIP acknowledges HHS' concern about the impact of choice overload for consumers in certain markets and their ability to meaningfully differentiate between a considerable number of plan choices. However, consumers on the Exchanges have many different needs and preferences for health coverage. For example, some consumers are price-conscious and prefer plans with lower premiums and high-value networks, while others value access to a variety of specialists and prefer plans with broad networks. Some consumers may prefer specific plans that contract with a particular health system or group of providers. Under this proposal, issuers would not be able to offer the range of network options available today and would be forced to make strategic decisions about which networks and plan offerings are available, stifling issuers' ability to innovate and expand plan designs. Some issuers also offer different benefit tiers in each of their plan offerings or include plan options that incorporate supplemental benefits like vision or dental coverage into their base plan. The proposed non-standardized plan limitation would not allow for the current amount of benefit tiers or supplemental plan options available today and stifle innovation for future offerings and expansions.

AHIP has particular concern about the timing and administrative challenges of the proposed changes. AHIP has partnered closely with its members, HHS, states, and other stakeholders to prepare for the forthcoming wave of Medicaid redeterminations that are to begin as early as February 1 and will continue through March 2024 (depending on when a particular state begins and concludes its process). At the same time, HHS is proposing changes that, according to estimates included in the preamble, could eliminate over one hundred thousand plan options and require up to one-quarter of FFE enrollees to switch to a new plan. Enrollees who have recently enrolled in Exchange coverage from Medicaid may have to switch again at the start of 2024. This significant disruption of the Marketplace at a critical time for coverage transitions from Medicaid to the Exchange would pose substantial operational challenges for plans, including notice and reenrollment requirements, and result in widespread consumer confusion and disruption of care.

Additionally, the product development process is already in progress and depending on the timing of the Payment Notice Final Rule, state filing processes would likely already be underway. Issuers have already made strategic decisions about plan offerings and participation and finalizing these changes for the 2024 plan year would result in significant operational challenges and rework, jeopardizing the ability for issuers to continue offering coverage in existing service areas.

Limiting non-standardized plan options is not the best method to improve the plan selection process for consumers. We encourage HHS to work with issuers to improve consumer decision support tools available on healthcare.gov to assist consumers with plan selection and the overall plan shopping experience and find the best plan that fits their needs. Optimized consumer tools to filter plan options, describe plan features, assess consumer health care utilization, and improve the plan selection process would benefit consumers more than limiting non-standardized plan options. We offer additional recommendations on improving consumer decision support tools in Section V of our comments below.

As an alternative to limiting the number of plans, AHIP recommends that HHS restore a meaningful difference standard instead of a numerical limitation. Restoring a meaningful difference standard would ensure that plans on the Exchange within each metal tier are truly different from one another and provide different options for consumers without sacrificing the different features and options that are available today. A meaningful difference standard would simplify the consumer shopping experience and allow for easier comparison between coverage options. We recommend that HHS lower the threshold included in a meaningful difference standard from \$1,000 to \$500. A threshold of \$1,000 is extremely high and does not account for consumer preferences, particularly for price-sensitive consumers that may prefer a higher monthly premium with a lower deductible limit, or vice versa. A \$500 standard would incorporate additional flexibility and options for consumers with varied budgets and preferences. A new meaningful difference standard should also build upon the previously codified standards

and incorporate updated factors such as provider networks, plan design, cost-sharing, HAS eligibility, and other features, not just a deductible variation. Consumers shop for plans with a number of different priorities in mind, and only differentiating plans based on deductibles does not adequately account for these important plan differences.

Second, if HHS proceeds with any changes to limit non-standardized plan options or reinstate meaningful difference standards, we recommend that HHS compare plans at the network ID level, not by network type. The product network type category is a broad definition based on legal structure and covered benefits and does not capture key differences in provider networks, such as specific in-network providers and health systems, network breadth, or other important distinctions that are meaningful for consumers. Modifying the limitation to compare plans at the network ID level would ensure that different consumers looking for specific types of networks still have high-value, broad, or specific health system-affiliated options. If HHS does not make this change, we are concerned that consumers will no longer have access to these types of networks, which are extremely popular with some consumers for their unique benefits. In addition, we recommend that HHS compare product type to allow for additional variation of benefit tiers, supplemental benefits, telehealth or other benefit options into their base plan.

We further recommend that HHS exempt certain plan designs required by states from the standard, if finalized. Some states require issuers to offer plans with specific benefit and cost sharing structures. When a plan is offered in order to meet a state requirement like this, it should not count towards the HHS limit on non-standardized plans.

Recommendations:

- **Do not limit non-standardized plan options for the 2024 plan year due to the market uncertainty and disruption caused by the Medicaid redetermination process.**
- **Improve healthcare.gov consumer decision tools to educate and empower consumers during the plan selection process.**
- **Restore a meaningful difference standard that reduces the deductible differential to \$500 and incorporates stakeholder feedback and other factors that consumers value.**
- **If CMS pursues any limitations on non-standardized plan options, including a meaningful difference standard, differentiate plan offerings at the network ID level, not network type, and exempt plan designs that are already required by states.**

II. Standardized Plan Options (§ 156.201)

AHIP appreciates HHS' proposal to make limited modifications to standardized plans for the 2024 plan year and encourages HHS to maintain consistency in standardized plan design to limit enrollee disruption and confusion. AHIP has significant concerns about HHS' proposal to limit issuers' ability to classify prescription drug tiers for standardized plans. Issuers

design prescription drug tiers based on clinical standards to maximize efficacy, quality, and affordability for enrollees, and they are often standardized at a product or issuer level. Mandatory formulary requirements do not adequately reflect patient-centered value definitions, such as adherence, pill burden, administration, absenteeism, adverse reactions, short- and long-term considerations, and many other factors. Formulary placement requirements also undermine the role of Pharmacy & Therapeutics Committees that review clinical evidence and guidelines, effectiveness, cost, and additional rationale to determine proper tier placement.

As pharmaceutical innovation has progressed and the drug market continues to evolve, the traditional viewpoint that generic drugs are the lowest-cost or highest value option is not always the case. HHS' proposed changes to drug tiering in standardized plans would not account for high-cost generic drugs on higher tiers, such as Zolpidem, Estradiol, Diclofenac Sodium, Sildenafil and Tadalafil, or whose orphan status grants a monopoly. It would also impact complicated biologics that lack competition because of the difficulty of production, or scenarios where brand drugs, such as insulin or diabetic test strips, are placed onto a lower-cost tier, including situations where competitive pressure has brought the price of brand drugs on par with non-brand drugs. This proposal would also incentivize manufacturers to raise the cost of certain drugs to take advantage of mandatory tier placement. Together, these impacts would ultimately increase prescription drugs costs, and drive-up premiums for all consumers because of limits on permissible rating variation, and result in higher deductibles due to AV constraints.

Finally, issuers would need considerable time to implement and operationalize HHS' proposed formulary placement requirements. If HHS finalizes its proposal, it should not impose the requirements before the 2025 plan year, as there is insufficient time for issuers to accommodate necessary technology and process updates and modify their formularies for 2024.

HHS requests comment on the potential to incorporate additional prescription drug tiers into standardized plans for future plan years. AHIP supports this approach and believes that additional tiers provide value to consumers and flexibility for plans to effectively manage their prescription drug costs and coverage. For example, as more biosimilars come to market, additional tiers for preferred and non-preferred specialty tier drugs could allow for more flexibility to ensure optimal patient outcomes and limit patient out-of-pocket costs. Additional flexibility for preferred and non-preferred generics and preferred and non-preferred brand drugs are other examples of ways that plans can use additional tiers to design formularies that provide greater cost-sharing incentives to enrollees and prioritize cost-effective drugs that deliver better outcomes.

Before any future changes to standardized plans are proposed and adopted it is critical for AHIP and its members to better assess final trends from the 2023 plan year. Reviewing data on enrollment numbers is essential to understand the impact standardized plans had on consumer behavior and plan selection, including who enrolled in standardized plans and how to best serve

them through future improvements to standardized plan design. For example, HHS could examine opportunities for flexibility in standardized plan design to allow for value-based arrangements and examine whether the current cost-sharing structures are popular with consumers. We recommend that HHS provide additional information about standardized plan enrollment and release a request for information to review public comment on whether these plans add value for consumers before making any additional changes to plan designs.

Recommendations:

- **Maintain flexibility for issuers to establish prescription drug tiers and do not finalize the proposed changes to drug tiering in standardized plans.**
- **Support inclusion of additional prescription drug tiers in standardized plan design for future plan years.**
- **Review and assess the impact standardized plan designs have had on consumer coverage choices and experiences before making any modifications to plan designs.**

III. Plans that Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

In 2023, HHS adopted new federal network adequacy time and distances standards for QHP issuers on the FFE. AHIP engaged Wakely Consulting Group to conduct qualitative interviews with AHIP member plans who offer QHPs in the FFE to understand the impact of these new requirements, identify areas of concern and offer suggestions for improvement.² Wakely identified concerns with adding providers, difficulties in contract negotiations, and needed HHS' process improvements.

First, AHIP member plans shared concerns about adding providers outside of their current provider network to satisfy the new federal network adequacy requirements. Issuers curate networks based on many considerations, such as care management, contracted rates, provider quality, and overall business goals. Similarly, providers participate in networks based on amount of membership and associated patient volume, reimbursement rates, and desire to participate in a specific market, such as Medicare versus the commercial market. Network adequacy requirements can force issuers to contract with additional providers simply to meet federal requirements, resulting in higher-than-average reimbursement rates, and raising premiums and out-of-pocket costs for enrollees. They could lead issuers to contract with providers that have higher costs or lower quality of care due to lack of care management information, out-of-network referral patterns, or other factors that are inconsistent with a plan's intended design. The report includes illustrative examples of these scenarios detailed by AHIP member plans.

² Wakely, Network Adequacy Report, 2023. <https://www.ahip.org/resources/network-adequacy-report>

AHIP member plans also shared concern about the federal network adequacy requirements' impact on provider contract negotiation. In addition to the factors included above, AHIP member plans noted significant difficulties in contracting with providers because of their affiliation with a particular health system. Many systems take an "all-or-nothing" approach to contracting, which requires the health plan to include the whole health system in a network, even in scenarios when only contracting with a small number of providers is necessary to fulfill the federal network adequacy standards. Provider consolidation continues to exacerbate this dynamic, and despite good faith contracting efforts, these negotiations remain largely unsuccessful. AHIP member plans identified difficulties in obtaining comprehensive provider data that can make contracting with providers to resolve specific network deficiencies difficult due to the lack of accurate information about specialties, location, or other data elements.

While AHIP member plans generally support network adequacy requirements and ensuring that consumers have robust access to high-quality care, the report identified several areas of concern that could have long-term consequences. Provider contracting and higher administrative burden detailed in scenarios included in the Wakely report have real impacts on higher provider reimbursement rates, increased premiums, and out-of-pocket costs. This in turn can lead to fewer plan offerings, and reduced choices for consumers. AHIP member plans also expressed concerns about enrollees receiving lower quality of care because of barriers to integrated care and care management within their health plans.

Based on the feedback from the Wakely report and further discussions with AHIP members, we have two recommendations to improve the network adequacy review process based on the first year of implementation. First, we recommend that HHS establish clear timelines for the review process. Advance notice of CMS timing and being able to anticipate feedback would improve communication and understanding of expectations, allowing issuers to respond in a timely way. HHS should identify a deadline to notify issuers whether their plan has been approved and to publish network adequacy templates as soon as possible to allow plans adequate time for submission and include options for drop down menus and inclusion of additional documentation. Second, HHS should utilize the exceptions process to time and distance standards when it is in the best interest of consumers and clearly communicate these instances to issuers. For example, issuers should be granted exceptions based on provider shortages, rural access issues, or significant geographic barriers in order to preserve access, as appropriate. Additionally, lack of consumer complaints and state regulator feedback are factors that could help inform HHS when granting exceptions is appropriate. AHIP appreciates that CMS has been receptive to feedback to date and has already incorporated preliminary feedback into the federal network adequacy review process and looks forward to working together on these additional improvements.

HHS proposes a limited exception from the requirement for issuers to use a provider network for SADPs where it would be prohibitively difficult to do so. HHS' analysis in the preamble discusses the difficulties that SADPs in rural areas can have in establishing provider networks. In

order to preserve access to coverage in these areas, we ask HHS to finalize this provision to establish a limited exception for SADP issuers and include a reference to the exception in the 2024 Letter to Issuers. We recommend HHS develop a pre-approved form for SADP issuers to request the exception and permit an abbreviated filing for subsequent years if a SADP filed the full request in a prior year.

Finally, we recommend that HHS adopt a voluntary telehealth credit toward network adequacy standards. Telehealth is a significant and growing method of care delivery, particularly during the COVID-19 pandemic, and has proven to be an effective way to expand access to high-quality care. HHS has acknowledged the benefits of telehealth and should continue to evaluate ways to improve access, particularly in rural areas or areas with significant provider shortages. The Medicare Advantage program provides a 10 percent credit for contracting with telehealth providers, and HHS should explore a similar approach with NAIC and relevant stakeholders.

Recommendations:

- **Establish clear timelines for the network adequacy review process, including a deadline to notify issuers whether their plan has been approved under the process.**
- **Provide additional flexibility in the exceptions process to allow for exceptional circumstances with clear criteria around when these exceptions are necessary to preserve access for enrollees.**
- **Finalize the limited exception from the requirement for issuers to use a provider network for SADPs where it would be “prohibitively difficult”.**
- **Adopt a voluntary telehealth credit toward network adequacy standards.**

Compliance with Appointment Wait Time Standards

AHIP requests that HHS provide additional flexibility around appointment wait time standards and allow ample opportunity for stakeholder input and testing before implementation. In our comments on the 2023 Payment Notice and related Paperwork Reduction Act notice, we raised significant issues regarding issuers’ ability to have an impact on wait times, especially given the significant staffing shortages that continue to plague providers. Adding provider wait time information requests will add additional burden on already overwhelmed providers and staff and will likely encounter difficulty with response rates. At the same time, issuers are still adjusting to the new processes for federal network adequacy review of time and distance standards. As detailed in the previous section, additional time is necessary to refine and improve existing processes and address outstanding issues. We encourage HHS to delay appointment wait time standards until plan year 2025 to resolve existing concerns and work with stakeholders to develop and implement new standards assessing appointment wait time.

There are many outstanding details regarding the assessment and attestation of appointment wait times that will require definition, testing, and refinement before implementation. Issuers need more specific guidance around data elements and collection methods, attestation, and compliance

processes. Appointment wait time standards are difficult to assess and reliably replicate. These metrics can also vary widely based on specific patient needs and circumstances, collection methods, or in scenarios where patients prefer to see a particular provider or specialists. Attestation of wait time standards could also raise concerns in instances where issuers cannot reliably verify that information is accurate or where conditions can change based on provider shortages or access issues. Wait time standards would also benefit from alignment with existing NCQA appointment availability standards that use business days as the reporting metric. We encourage HHS to work with stakeholders to define and develop a framework for assessing appointment wait time standards and provide opportunities for feedback.

Recommendations:

- **Delay appointment wait time standards until the 2025 plan year.**
- **Work with stakeholders to establish an appointment availability framework and test appointment wait time standards prior to implementation.**
- **Ensure that issuers have additional details about measurement and can test whether they meet compliance standards before requiring attestation.**
- **Align wait time standards with existing NCQA appointment availability standards and avoid regulatory duplication.**

IV. Essential Community Providers (§ 156.235)

While AHIP recognizes the importance of a robust network of ECPs, AHIP has concerns about requiring QHPs to contract with at least 35 percent of FQHCs and Family Planning Providers at this time. Moving from a threshold across all categories to requiring a threshold for specific categories limits issuer flexibility to account for variables such as provider shortages and distribution, enrollee population distribution, and rural access, and will make it more difficult for issuers to meet these thresholds. System-wide initiatives to address health equity and access and improve the health care workforce should continue to be one of HHS' priorities. While these initiatives are underway, we encourage HHS not to increase ECP thresholds.

AHIP also has concerns about the proposal to add Rural Emergency Hospital (REH) to the Other ECP Category. Adding REH to the Other ECP category is premature as additional time is needed to evaluate implementation efforts and provider enrollment. 2023 is the first year in which eligible hospitals can apply to convert to an REH. States must pass new laws to permit licensure and registration to accommodate this new provider type, which is still underway. Furthermore, providers are still evaluating whether to apply to convert to an REH given regulations governing key aspects of this new designation were recently finalized in November 2022 and additional guidance was released on January 26th.³ We recommend that HHS delay this proposal to

³ Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation. <https://www.cms.gov/files/document/qso-23-07-reh.pdf>

accommodate and monitor these ongoing implementation efforts and, if appropriate, repropose it for the 2025 plan year.

We also ask HHS to consider provider outreach attempts as sufficient in fulfilling ECP standards. As outlined in our comments on the 2024 Draft Letter to Issuers, issuers encountered many challenges during the 2023 QHP certification process that made it difficult to finalize contracts with high-quality providers. This included unresponsive providers, providers not contracting in good faith, and difficult decisions to contract with low-quality providers who otherwise would not meet their network standards in order to fill network gaps. In addition, there are situations where a number of clinics may be owned or operated by the same entity and make contracting decisions at the corporate level. In these cases, one denial from the entity should fulfill the good faith contracting requirements. If this policy is finalized, issuers could be forced to offer contracts to low-quality providers in situations where high-quality providers are unresponsive to issuer outreach attempts. We therefore recommend HHS consider attempted outreach as sufficient to fulfill ECP standards.

Recommendations:

- **Do not adopt new requirements to contract with at least 35 percent of FQHCs and Family Planning Providers.**
- **Delay addition of Rural Emergency Hospitals to the Other ECP Category until plan year 2025.**
- **Consider provider outreach attempts as sufficient to fulfill ECP standards.**

V. Annual Eligibility Redetermination (§ 155.335)

AHIP supports HHS' goal to ensure consumers understand and consider the most cost-effective plan options. However, we caution against proposals that could override consumer choice when a consumer's selected QHP is still available. Revising the reenrollment hierarchy to reenroll a consumer in a different QHP (e.g., silver instead of bronze) than they initially selected when their plan is still available would harm consumer choice and cause unnecessary abrasion and confusion.

Consumers actively choose their health plan for several reasons, including but not limited to net premium, provider network, and out-of-pocket costs. While some consumers may prioritize net premium over other considerations, others may choose a plan based on a specific carrier, provider network, and cost-sharing arrangements, or based on their ability to enroll in a high-deductible health plan or contribute to an HSA. This proposal assumes consumers value income-based CSRs and net premium above all other factors – and while this may be true for some consumers, it is incorrect to assume this applies to all consumers, especially those who actively select a plan that supports their own, unique health conditions.

In addition, this policy proposal does not account for situations where consumers fail to make premium payments. Many enrollees stop making premium payments because they no longer need Marketplace coverage but fail to cancel their coverage. An Exchange could cause consumer confusion and abrasion and even a tax liability if a consumer is passively reenrolled into a Marketplace plan with APTC for which they are no longer eligible.

For similar reasons, AHIP also has concerns about automatically enrolling consumers into another metal level when their QHP is no longer available. Overall, it is our preference that consumers return to the Exchange to actively make a new plan selection. Consumers who are automatically reenrolled in a metal level they did not actively select may end up confused, frustrated, and have difficulty understanding their new plan's benefits. These decisions should not be made passively, and without transparency or active consent. Consumers should be empowered through the plan selection process and given the necessary tools to make the best decisions for their health care needs.

To preserve consumer choice, HHS should improve consumer decision support tools and education around silver plans. This year, HHS added a reminder prompt to the healthcare.gov plan selection process when consumers selected a non-silver plan, notifying them they could be missing potential savings by selecting a silver plan and making them confirm their plan selection before proceeding to check-out. Tools like these ensure consumers adequately consider whether a silver plan may be the best option for them, while maintaining consumer choice over the plan selection process. HHS could also provide additional educational and marketing materials to CSR-eligible enrollees prior to Open Enrollment. For example, HHS could modify renewal notices to include language that notifies CSR-eligible enrollees that they may be eligible for lower cost plans with lower cost-sharing by selecting a silver plan. We encourage HHS to examine these options to improve consumer decision support and education.

If HHS finalizes this proposal, AHIP is concerned that existing requirements around renewal notices could cause mass consumer confusion if consumers receive two separate renewal notices with different information about their health plan selection. The Guaranteed Renewability of Coverage Requirements (45 CFR § 147.106) require carriers to send notices to members 180 days, 90 days, or 60 days prior to discontinuation or renewal, depending on specific mappings and state standards. In order to coordinate any mapping hierarchy changes with issuer renewal and change notices, issuers must receive mapping information from the Exchange well in advance of the Batch Auto-Reenrollment (BAR) process. Under current processes, consumers would likely receive one notice from their issuer prior to the reenrollment process, informing them of continued enrollment in their selected bronze plan, and a second notice from the Exchange advising them that they will be re-enrolled in a silver plan. Since this may be impossible to coordinate given current operational and timing requirements, AHIP recommends HHS allow issuers to modify renewal notices. For example, issuers could be provided a similar

renewal notice flexibility to last year, which encouraged consumers to check healthcare.gov for the most up-to-date information on net premium, deductibles, and out of pocket costs.

We also urge HHS to consider the impact of the proposed changes as a whole with the upcoming wave of Medicaid redeterminations. Implementing new non-standardized plan limits, plan marketing name requirements, and revisions to the reenrollment hierarchy would cause massive disruptions to the Marketplaces, especially as states conduct Medicaid redeterminations. We encourage HHS to consider how to sequence these proposals and their cumulative impact on the Marketplace.

Recommendations:

- **Do not automatically re-enroll consumers into an alternative QHP when the QHP a consumer selected remains available on the Exchange or when their previous QHP is no longer available.**
- **Improve consumer decision support tools to empower consumers to make the best coverage decisions for their unique health care needs.**
- **If HHS moves forward with this proposal, provide flexibility for issuers to modify renewal notices to ensure consumers have accurate and clear information.**
- **Consider impacts of Medicaid unwinding on Marketplaces and related policy proposals, including non-standardized plan limits, plan marketing name requirements, and revisions to the reenrollment hierarchy.**
- **Engage stakeholders in any future policy considerations regarding the reenrollment hierarchy.**

Requests for Information

With regard to HHS' request for information, AHIP recommends HHS maintain the current reenrollment hierarchy and empower consumers to make the best health care coverage decisions for their needs.

- AHIP opposes incorporating net premium and total out-of-pocket costs throughout the Exchange reenrollment hierarchy for future years. While the maximum out of pocket limits annual costs for enrollees, it is not a good estimate of consumers' actual out-of-pocket costs, especially for those with lower health care costs.
- AHIP opposes reenrolling consumers into the lowest cost silver plan (LCSP) in the following year if the consumer chose the LCSP in the current plan year. Individuals' health needs and circumstances change from year to year, and the enrollment hierarchies should not assume that an enrollee's reason(s) for selecting the LCSP one year would also lead them to select the LCSP the following year.
- AHIP opposes zero-dollar plan reenrollment for consumers who go into delinquency or fail to make a binder payment. There are many reasons besides affordability that a consumer might stop making premium payments or might shop for a plan but not effectuate coverage. For example, many consumers simply stop making premium

payments (instead of cancelling ACA coverage) when they become eligible for other coverage.

VI. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

HHS Risk Adjustment (§ 153.320)

Data for Risk Adjustment Model Recalibration for 2024 Benefit Year

HHS' approach to recalibrating the risk adjustment model is to use the three most recent consecutive years of enrollee-level EDGE data available at the time the draft recalibrated coefficients are published in the proposed payment notice. AHIP has concerns about the precedent of deleting coefficients in the risk adjustment model to address data anomalies. If 2020 benefit year data is unique and presents a challenge for risk adjustment model calibration because of the impact of the COVID-19 pandemic, it should not be used to recalibrate the models. In addition, issuers would benefit from greater transparency into the data used to develop HHS' options to address 2020 benefit year data in order to fully evaluate these proposals, as some coefficients for specific RXCs experienced significant decreases compared to the 2023 model coefficients. We recommend that HHS publish the individual benefit year coefficients so stakeholders can evaluate HHS' proposed options and review trends over time.

Recommendations:

- **Do not include 2020 benefit year data in the risk adjustment recalibration for the 2024 benefit year.**
- **In the future, publish the individual benefit year coefficients used to develop the proposed model.**

Request for Information: Payment HCC for Gender Dysphoria

AHIP believes that every American deserves access to high-quality, affordable health care, regardless of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. AHIP continues to support federal law protections that prohibit discrimination based on gender identity, sexual orientation, or pregnancy status and strongly supports ensuring that appropriate gender-affirming care is available and accessible to enrollees. We also share HHS' commitment to ensuring benefit designs and coverage decisions reflect evidence-based guidelines and recommendations and do not restrict coverage related to gender identity.

To that end, we support HHS' consideration of addressing gender dysphoria in the risk adjustment model and believe that it could help reduce barriers to care and enrollment for LGBTQ+ individuals. We encourage HHS to work with stakeholders to determine how best to incorporate gender dysphoria into the risk adjustment model and provide necessary education in advance of its introduction to ensure that any related diagnoses are coded appropriately.

Recommendations:

- **Support inclusion of gender dysphoria in the risk adjustment model.**
- **Convene a stakeholder process to determine how to best incorporate gender dysphoria into the risk adjustment model.**

Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, and 153.710)

Collection and extraction of the Qualified Small Employer Health Reimbursement Account (QSEHRA) indicator

As noted in our 2023 Payment Notice comments on data collection, AHIP appreciates HHS' efforts to improve and increase data collection for risk adjustment purposes but continues to face significant challenges with certain data elements that are not collected or available to issuers.⁴ QSEHRA data is not necessary for risk adjustment purposes, difficult to obtain, not able to be reliably distinguished by consumers when available and affects a small population of enrollees. HHS should consider alternative methods of collecting this data, such as from employers that sponsor QSEHRA plans or from the Exchanges during enrollment.

Recommendations:

- **Do not finalize the proposal to collect a QSEHRA indicator.**

Extracting Plan ID and Rating Area

In our 2023 Payment Notice comments, AHIP shared concerns about patient privacy and protecting sensitive health care information and opposed the collection and extraction of rating area, plan ID, zip code and subscriber indicator. We continue to oppose the data collection proposals finalized in the 2023 NBPP and ask HHS to reconsider these requirements. HHS has set up a distributed data environment to safeguard the transmission and storage of sensitive information for this purpose and avoid exposure of identifiable information about specific issuers or members. Our previous concerns about data collection remain and expanding data extraction to previous years will further undermine these efforts. AHIP opposes the use of this data for purposes outside of risk adjustment and believes HHS should explore alternatives for data analysis.

Recommendations:

- **Do not finalize the proposal to extract plan ID and rating area from the 2017-2020 benefit year data submissions.**

⁴ AHIP Comments on Notice of Benefit and Payment Parameters for the Individual Market, 2023.
<https://www.ahip.org/resources/ahip-comments-on-notice-of-benefit-and-payment-parameters-for-the-individual-market-2023>

Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS-RADV) (§§ 153.350 and 153.630)

Materiality Threshold for Risk Adjustment Data Validation

Using billable months instead of premium will maintain a more consistent threshold not impacted by premium increases and eliminates the need for the materiality threshold to be updated over time. For these reasons, AHIP supports this proposed change.

Recommendation:

- **Finalize proposal to change RADV materiality threshold to 30,000 total billable member months (BMM) statewide.**

VII. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

Exchange Blueprint Approval Timelines (§ 155.106)

States and issuers require adequate time to accommodate an Exchange's transition to a different structure. These transitions demand significant operational and technical lifts, including but not limited to changes to issuer information technology systems, member communications, and marketing materials. Furthermore, states and issuers must test new processes prior to implementation to ensure a smooth transition. We are concerned that without assurance of HHS' approval of the transition well in advance, additional implementation risks will surface due to intensive implementation efforts, such as IT contracting. Even with the current deadlines, some State-Based Exchange (SBE) transitions struggled to adequately prepare for their transition and experienced extreme implementation challenges, negatively impacting both states and issuers and harming the consumer experience. Anything less than the current timeline would prove hugely burdensome to state regulators and issuers and could cause major disruption for consumers in transitioning Marketplaces.

Recommendation:

- **HHS should maintain the current Exchange Blueprint approval and conditional approval deadlines to allow issuers sufficient time to make operational changes necessary to accommodate a new Exchange structure.**

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

AHIP appreciates HHS' efforts to promote coverage continuity. This proposal would remove unnecessary barriers that impede opportunities for greater consumer engagement and education, especially for medically underserved communities and those impacted by Medicaid redeterminations. AHIP supports this policy change and further applauds the Department's

efforts to get more Americans covered by increasing funding to Navigator organizations ahead of 2023 Open Enrollment. We look forward to working with HHS to advance policy changes that mitigate coverage gaps and support coverage transitions for individuals at risk of losing Medicaid coverage during the Medicaid unwinding period.

Recommendation:

- **Finalize proposed changes to allow Navigators, Assistors, and related personnel to provide enrollment assistance to consumers through direct contact.**

Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs (§ 155.220)

AHIP supports HHS' three proposed changes to agent, broker, and web-broker processes. However, we caution against implementing any changes that create additional requirements or administrative burden for issuers in scenarios where they are not directly involved. Issuers are not directly involved in gathering and assisting consumers with data used in the enrollment process, cannot verify the accuracy of the information provided, and therefore should not have liability under any of the proposed requirements.

Recommendation:

- **Finalize the proposed provisions relating to agent, broker, and web-broker requirements, so long as it does not place any new requirements on issuers.**

Eligibility Standards (§ 155.305)

AHIP supports the proposed changes to determine an applicant ineligible for APTC only if the applicant has a Failure to Reconcile (FTR) delinquent status for two consecutive years. Extending the timeline for ineligibility determinations provides Exchanges with additional flexibility with their FTR operations, and more importantly, eliminates coverage gaps and ensures continuity of coverage for consumers.

Recommendation:

- **Finalize proposed changes to the FTR process.**

Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

AHIP supports HHS' proposed change to accept an attestation of household income when IRS tax return data is not available. This proposed change will help ensure continuous coverage for enrollees whose household circumstances or filing status changes or who are not required to file a tax return. Health insurance providers understand some consumers may need additional time to

obtain information related to household income. However, a blanket 60-day extension may not be necessary for all consumers and could slow application and enrollment processes. Instead, we suggest allowing Exchanges the option to extend the verification process for enrollees based on their specific circumstances.

Recommendations:

- **Finalize the proposed change to accept an enrollee's attestation of projected annual household income when IRS tax return data is not available.**
- **Provide Exchanges the option to receive a 60-day extension for verification processes.**

Special Enrollment Periods (§ 155.420)

AHIP supports policy changes that mitigate coverage gaps and maintain a stable risk pool. As such, we generally caution HHS from implementing SEPs that could have significant adverse consequences for the individual market. Constant enrollments and disenrollments undermine the stability of the individual market and could result in higher premiums and narrower networks and limit consumer choice. However, we understand exceptional circumstances such as the upcoming Medicaid unwinding period may present the need for tailored SEPs that encourage timely coverage transitions within a reasonable timeframe. We recommend HHS work with issuers to implement policy changes that encourage consumers to enroll in and maintain continuous coverage.

Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

AHIP supports policy changes that ensure consistent access to coverage, especially for those individuals who face loss of minimum essential coverage (MEC). The proposed SEP will allow for seamless transitions to Marketplace coverage during a time when more than a quarter of the U.S. population could be disenrolled from Medicaid. We appreciate these changes will be at the option of the Exchange, and further recommend this proposal only apply to states that have elected the option to terminate Medicaid or Children's Health Insurance Program (CHIP) coverage mid-month to avoid overlapping coverage and large number of enrollees not beginning coverage on the first of the month, which is common practice. We also urge HHS to ensure coverage effective date changes remain prospective, not retroactive.

Recommendations:

- **Finalize changes to the coverage effective date rules only in states that terminate Medicaid or CHIP coverage mid-month.**
- **Do not make changes that would result in retroactive or mid-month effective dates.**

Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

AHIP is committed to helping mitigate coverage losses and gaps in coverage for those who lose their Medicaid coverage during the upcoming Medicaid unwinding period. The proposed SEP will remove unnecessary administrative hurdles and provide consumers necessary additional time to secure Marketplace coverage in the event they are unable to reenroll in Medicaid coverage without an overly long election period.

Providing ninety days to select a Marketplace plan provides needed flexibility for at-risk consumers, while maintaining the stability of the individual market. We are concerned the recently announced Medicaid Unwinding SEP could have severe long-term consequences for issuers and consumers and are still evaluating the impact of this guidance.⁵ Enacting a 16-month open enrollment period puts creates incentives for consumers to defer coverage until July 2024; encouraging consumers to only enroll in coverage when they need care. We look forward to working with HHS promote policies that help consumers apply for and enroll in subsidized Marketplace coverage in a timely manner.

Recommendations:

- **Finalize the proposal to allow Exchanges the option to implement a new SEP for consumers who lose Medicaid coverage.**
- **Adopt SEP with an immediate effective date to provide more opportunities for coverage continuity.**
- **Consider risks associated with Medicaid Unwinding SEP.**

Plan Display Error Special Enrollment Periods (§ 155.420(d))

HHS should implement policies that encourage consumers to enroll in and maintain continuous coverage. Changes in provider networks occur frequently and often with little notice to issuers. Despite these challenges, issuers are prepared to respond to network disruptions to ensure consumers have consistent access to high-quality providers and facilities. Network disruptions do not change the value of the health plan, as issuers adapt their networks to changing circumstances. Furthermore, existing QHP and *No Surprises Act* continuity of care provisions protect consumers from disruptions in care by requiring notice of network changes and permitting enrollees to continue care with out-of-network providers under certain circumstances. Permitting consumers to change plan selections based on semi-regular occurrences could have significant adverse consequences for the individual market.

Recommendation:

- **Do not adopt a new SEP based on provider contract terminations.**

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

⁵ <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>

FFE and SBE-FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

AHIP appreciates the insight that HHS provides in the preamble related to calculation of issuer user fees and relevant factors, including enhanced premium tax credits, enrollment projections, transition to State-based Exchanges, Section 1332 waivers, medical inflation, and other developments. We support HHS' proposed rates and agree with HHS' rationale that sufficient funding is available to lower the user fee rates while continuing to fund Exchange operations and activities at a consistent level.

AHIP reiterates our previous comments that HHS should consider a per member per month (PMPM) user fee to better align with increasing enrollment and to promote affordability and avoid higher fee amounts based solely on premium increases. AHIP also continues to urge HHS to offer additional transparency about the use of issuer user fees, the HHS methodology in determining user fees, and how issuer user fees support HHS' policy goals for the Exchanges.

Recommendations:

- **Finalize the 2024 user fee rates as proposed.**
- **Consider an alternative user fee methodology, such as a per member per month (PMPM) amount rather than percentage of premium.**

Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

AHIP supports the Department's goal of ensuring consumers have accurate, up to date information during the plan selection process. Issuers often name their plan after a valuable feature the plan offers, such as zero-dollar premiums. Issuers believe these naming conventions help consumers more easily identify plans that are of value to them – not mislead them.

However, AHIP acknowledges instances where plan marketing names may mislead consumers. Additional oversight of plan marketing names could reduce consumer confusion and build confidence in the plan selection process. While we support this effort, we have concerns with how HHS may implement this policy.

First, we caution against including additional requirements during the QHP certification process. New requirements would add significant administrative burden during a time when issuers are working to implement several new standards and requirements.

In addition, the proposed policy would require all information included in plan and plan variation marketing names relate to plan attributes in the Plans & Benefits Template. However, the Plans & Benefits Template has limitations, as it does not capture key benefits and details that consumers may be searching for during the plan selection process. For example, the template

currently does not capture benefits such as virtual care or benefits aimed at addressing social determinants of health, such as free transportation. As such, we recommend against adopting strict implementation standards, specifically those that require all information related to plan attributes to correspond in materials submitted as part of the QHP certification process since some of these materials have limitations and do not adequately capture all of a plan's benefits.

Furthermore, several states already regulate plan marketing names and have detailed requirements regarding what plans can and cannot include in their marketing names. Issuers work with states to ensure these requirements capture plan differences and provide meaningful information to consumers about plan benefits. We urge HHS to defer to states with adequate marketing standards, rather than adopting duplicative requirements in those states.

To better communicate important plan benefit information to consumers, HHS should improve the healthcare.gov plan display. Issuers work to ensure that consumers have the necessary tools to make informed decisions when selecting a health insurance plan by appropriately detailing plan benefit design, cost-sharing requirements, and other features in the plan details page on healthcare.gov. However, these details are not always displayed in a clear manner on healthcare.gov and are sometimes difficult for consumers to locate. For example, a consumer may not be aware that a certain plan covers primary care visits since they would have to scroll and/or click through three different display topics before reaching that information (1. Plan Details, 2. Expanding Costs for Medical Care, and 3. View Limits and Exclusions). The inability for issuers to effectively communicate key plan benefits through the healthcare.gov display can lead consumers to misunderstand plan benefits and miss out on plans that may be better fit for their health needs. The healthcare.gov display should be refined to ensure that consumers can understand the different innovative features that differentiate plans without having to include these features in the plan name. We recommend HHS convene stakeholders to evaluate ways to improve the healthcare.gov plan display, including providing a designated space within the standard viewing pathway for issuers to highlight key plan benefit or displaying complex cost-sharing structures on the initial plan view. If HHS finalizes this proposal, we recommend HHS provide additional materials and examples to clarify the plan marketing name requirements.

Recommendations:

- **Caution against including additional requirements in the QHP certification process to avoid unnecessary administrative burden.**
- **Defer to state marketing requirements, where applicable, to avoid duplicative requirements.**
- **Do not adopt strict implementation standards that require all information related to plan attributes to correspond to materials submitted as part of the QHP certification process, as some of these materials have limitations and do not adequately capture all of a plan's benefits.**

- **Improve the healthcare.gov plan display so consumers have easy access to important information about plan benefits.**
- **If finalized, provide additional clarity and specific examples of acceptable and unacceptable marketing names.**

Termination of coverage or enrollment for qualified individuals (§ 156.270)

Issuers support ensuring consumers have timely information about their health care coverage. However, issuers need sufficient time to process enrollee payments received in the few days before and after a payment due date to ensure consumers do not unnecessarily receive a notice of payment delinquency. As such, we propose a timeliness standard for sending a notice of payment delinquency of 10 business days from the discovery of the delinquency.

We propose the standard start on the date from which the delinquency is discovered to allow flexibility for situations in which premium payments are returned due to insufficient funds. Often, banks do not advise issuers of the insufficient funds until several days past the date of payment. For example, some issuers received notice of insufficient funds 20 days after the date of payment. Adopting a standard of 10 business days would allow issuers to have additional time and information related to payment delinquency and communicate more effectively with enrollees.

Recommendation:

- **Adopt a timeliness standard of 10 business days from the discovery of the delinquency.**



January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

RE: CMS–9899–P
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment
Parameters for 2024

Dear Administrator Brooks-LaSure:

Haystack Project appreciates the opportunity to comment on the above-referenced Proposed Rule (the NBPP). The Affordable Care Act and the health insurance marketplaces created under it are critical to achieving the goal of equitable, affordable access to quality health care for all Americans, and particularly important to individuals with rare and ultra-rare conditions.

Haystack Project is a 501(c)(3) non-profit organization enabling rare and ultra-rare disease patient advocacy organizations to coordinate and focus efforts that highlight and address systemic reimbursement obstacles to patient access unique to rare diseases or particularly pronounced in extremely rare diseases. Haystack Project is committed to educating policymakers and other stakeholders about the unique circumstances of extremely rare conditions with respect to product development, commercialization, and fair access to care. Our core mission is to evolve health care payment and delivery systems with an eye toward spurring innovation and quality in care toward effective, accessible treatment options for all Americans living with or caring for someone with a rare or ultra-rare condition.

Our rare disease communities struggle to navigate health system challenges in disease states where unmet need is high, and treatment delays and inadequacies can be catastrophic. Our comments offer our insights and recommendations to enable CMS to build upon its efforts to ensure that the benefits to patients within the ACA marketplace confer equally to individuals

regardless of their race, financial resources, health care needs, or the rarity of their health condition(s).

Background

Health care for individuals with rare and ultra-rare conditions can be relatively high-cost and often requires highly specialized clinicians to deliver quality care. Approximately 7,000 rare diseases have been identified to date, 90-95% of which have no FDA approved treatment. Cumulatively, rare diseases affect approximately 30,000,000 or 1 in 10 individuals in the U. Health care for individuals with rare and ultra-rare conditions can be relatively high-cost and often requires highly specialized clinicians to deliver quality care. Rare disease patients face substantial challenges from symptom emergence through treatment or management of their condition. These patients:

- See an average of 4.2 primary care physicians and 4.8 specialists before receiving an accurate diagnosis.
- Make an average of 2.4 out-of-state trips related to their diagnosis.
- Visit an emergency room an average of 3.7 times and - are hospitalized an average of 1.7 times for reasons related to their rare disease prior to diagnosis.
- Face a heightened risk of misdiagnosis.
- Have a very limited set of clinicians with disease-specific expertise, making it difficult for many patients to identify an experienced provider within their network, or even their state.
- Disproportionately rely on off-label use of treatments indicated for more common conditions to address disease symptoms and/or progression. Due to disease rarity, these off-label uses are seldom included within compendia.

In 2021, the Government Accountability Office (GAO) compiled a report to Congress entitled “RARE DISEASES: Although Limited, Available Evidence Suggests Medical and Other Costs Can Be Substantial” in collaboration with EveryLife Foundation for Rare Diseases and the National Organization for Rare Disorders. The report assessed the challenges rare disease patients face accessing diagnostic and treatment services as well as the personal and economic costs associated with treatment delays. Among its many findings, the GAO found that rare disease patients are unable to access specialists due to geography or failure to receive a referral for follow-up care at initial symptoms, and often progress to more severe disease states by the time they receive an accurate diagnosis. Forty-one percent of rare disease patients also receive at least one misdiagnosis, and many are treated for a condition they did not have, and approximately 7 percent of rare disease patients reported that they were given a false psychological/psychiatric diagnosis that further impeded and delayed their treatment.¹

¹ GAO Report. [GAO-22-104235, RARE DISEASES: Although Limited, Available Evidence Suggests Medical and Other Costs Can Be Substantial](#)

Individually, these access challenges can present inconveniences, frustration, and delays in receiving care. Cumulatively, they can present an overwhelming burden for patients and their families.

Haystack Project generally supports CMS' proposals to expand access to coverage and streamline enrollment/re-enrollment processes.

Haystack Project appreciates that the Administration's ACA-related efforts have emphasized refinements that reduce health inequities and protect health care access for individuals with chronic conditions and other high-cost health care needs. We support CMS' policy refinements to ensure that individuals have the information they need to enroll in a plan that meets their health care needs, including:

- Repealing the regulatory provisions prohibiting assisters (Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselors) from going door-to-door or using other unsolicited means of direct contact to provide enrollment assistance to consumers. Haystack Project agrees that repealing the prohibition would enable assisters to reach a broader consumer base for enrollment assistance.
- Requiring agents to create and provide CMS with documentation that a consumer/representative has reviewed and confirmed the accuracy of eligibility application information before submission.
- Requiring that agents document and maintain (for at least 10 years) a record of consumer consent that includes name (consumer and agent), date of consent, and a description of the scope, purpose, and duration of consent.
- Permitting exchanges to find an applicant ineligible for advance premium tax credit (APTC) **only if** the applicant has a "failure to file and reconcile" (FTR) delinquent status for the two consecutive years for which tax data would be used to verify household income and family size.
- Modifying the Verification Process Related to Eligibility for Insurance Affordability Programs
 - o Require Exchanges to accept enrollee's attestation of projected household income where IRS tax return data is unavailable.
 - o Require that income inconsistencies receive an additional, automatic 60-day extension to the deadline for providing documentation to verify household income.
- Permitting Exchanges to implement a "new special rule" that consumers eligible for a special enrollment period due to loss of Medicaid or CHIP coverage will have up to 90 days after coverage loss to enroll in an Exchange plan.

Haystack Project continues to support CMS' elimination of the option for states to permit issuer substitution of benefits between EHB categories.

-

Haystack strongly supports CMS' decision to eliminate the ability for states to permit plan designs that substitute benefits between EHB categories. We commend CMS for its careful analysis and its decision to prioritize the coverage needs of patients with high-cost conditions over any future interest states may have in exercising flexibilities that alter the set of benefits conveyed by marketplace coverage.

Haystack Project is disappointed that CMS has not addressed areas of particular concern to individuals with very rare diseases.

Self-insured and large employer flexibilities to deem specific prescription drugs as “nonessential health benefits.”

In addition to the difficulties rare disease patients face in receiving a diagnosis, identifying an in-network specialist with disease-specific expertise, and identifying a treatment plan to manage disease symptoms and progression, individuals insured through employer-sponsored coverage are increasingly confronted with noncoverage when an FDA-approved therapy becomes available. Self-insured and large employer plans have leveraged benefit flexibilities (e.g., determining that specific prescription drugs are “nonessential” health benefits) to deny patient access to what may be the only therapeutic option to reduce disease burden and/or slow disease progression. The unfairness of declaring that what may be the only treatment available to address a patient’s life-threatening or life-limiting condition is “nonessential” is compounded by the fact that the significant costs incurred to pay out-of-pocket do not count toward the plan’s deductible or out-of-pocket maximum. This can be catastrophic for families impacted by a rare condition with a treatment that is deemed to be a non-essential health benefit. The policy likely widens health disparities between patients with sufficient financial resources and families with limited means. We urge CMS to revisit this policy and either revoke it or otherwise ensure that impacted patients have access to the treatment they need at a cost they can afford.

Patients with rare diseases and chronic conditions remain vulnerable to “discriminatory” plan designs implemented in the form of utilization management strategies and formulary design.

Haystack Project supported CMS' efforts to improve enforcement of the ACA prohibitions on discriminatory plan benefit design. In particular, Haystack appreciated that CMS articulated the general requirement that plan benefit limitations and coverage requirements be grounded in clinical evidence rather than driven by economic considerations. We strongly agree that a non-discriminatory plan design – **and its implementation mechanisms** - must be grounded in scientific evidence, including specialty society and disease-specific expert recommendations.

As we noted in our comments to the 2023 proposed rule, extremely rare diseases and their treatment regimens are not included in the compendia that many plans rely upon exclusively to determine coverage. Similarly, the impacts of general coverage inclusions and exclusions on rare disease patients are most often related to implementation rather than design and not readily ascertainable in plan documentation. We again urge CMS to (1) include opinion of

recognized, disease-specific experts as an evidence source for therapies used in treating or managing a rare condition, including rare cancers; and (2) develop a mechanism through which patients and clinicians can report on and resolve real world experiences that demonstrate a **discriminatory impact** or plan design that may not be apparent within the resources available for CMS review. Examples of a discriminatory impact that disproportionately impedes access to care for individuals with rare diseases include:

- **Step therapy protocols.** Step therapy is a well-accepted, frequently encountered utilization management strategy. Payers require patients to “step” through older, less costly treatments before allowing access to newer, often more innovative or targeted, and inevitably more expensive options. This may not be a problem in disease states for which several treatments are available, including generic options. However, individuals with extremely low prevalence conditions rarely have an FDA-approved treatment available, and any off-label uses of existing drugs are seldom found in the sources listed in the various compendia and other sources plans commonly rely on to determine coverage. This means that individuals with very rare conditions do not have the same protection from inappropriate step protocols that individuals with common conditions have, and the steps designed for more common diseases are frequently inappropriate within the context of off-label use in rare conditions. This is particularly true when step therapy protocols require failure on a treatment that is not useful in that disease and/or that may be harmful to the patient. Haystack does not expect that plans would maintain up-to-date clinical information on every treatment for every rare disease. We do, however, urge CMS to consider whether plans maintain an expedited review process and permit emergency doses for rare disease patients in determining whether plan designs are nondiscriminatory.
- **NDC “blocks” and “lock-outs”** – It is relatively common for plans to systematically block coverage of newly approved drugs for 6-12 months or longer under the rationale that formulary inclusion requires review of the plan’s pharmacy and therapeutics committee. These blocks apply to patients newly-seeking treatment as well as to those who have benefited from the treatment through clinical trial participation, open label extensions, and expanded access programs. Haystack recognizes that the mechanism has utility and may be a reasonable approach in more common conditions. Access delays for new drugs offering incremental benefits in efficacy, safety, or convenience over existing treatments may be frustrating, but they are generally not harmful to the patient. In rare conditions and rare cancers, however, declining access to what may be their only on-label treatment should be viewed as a failure to deliver essential health benefits. It is an example of the types of unintended consequences rare disease patients face throughout their health care journey and illustrates how applying policies with seeming equality drives real world inequities that can harm patients. An expedited formulary review process applicable to newly-approved treatments for rare diseases without on-label treatment options would mitigate the disparate impact that blocks and lock-outs exact on patients.

Once again, Haystack Project urges CMS to identify a mechanism through which patients can report real-world experiences of discriminatory plan design and/or discriminatory impact associated with coverage and benefit implementation. This would be helpful to patients, potentially reduce burden to clinicians, and enable CMS to identify additional examples of presumptively discriminatory plan design and implementation mechanisms.

Haystack Project urges CMS to implement additional policy refinements to reduce health inequities.

Our member organizations represent a diverse set of rare and ultra-rare disorders, some of which have known disparate impacts on communities of color. Unfortunately, Haystack and its member organizations face the same hurdles in identifying and quantifying these impacts as CMS has in addressing them. We do know that unless registry participation, outreach, and engagement is sufficiently representative of the total patient population, advocacy organizations remain uninformed of disparate disease burdens, treatment response, and access to care, and cannot advocate on behalf of **all** patients impacted by a rare condition. Haystack believes that CMS should take a partnership approach to addressing health disparities and inequities and that patient advocacy organizations can play a strong role in narrowing care gaps due to social determinants of health and systemic perpetuation of racial inequities.

Haystack Project member advocacy organizations have asked for support in illuminating and addressing the needs of non-white patients in their communities, and Haystack is responding with its Health Equity in Access to Treatments initiative. The goal of this program is to develop a “best practices” guide to empower our patient advocacy organizations to (i) evaluate their organization’s inclusiveness and representativeness, (ii) address care gaps, and (iii) incorporate the lived experience of all patients into their advocacy. Ultimately, we hope that each of our 70+ patient organizations will leverage their learnings to proactively drive initiatives toward reducing inequities related to systemic racism and social determinants of health that drive disparate access to treatment and health outcomes.

Haystack’s outreach efforts have revealed several areas of concern to patients that, if adequately addressed, could close care gaps and reduce health inequities.

- Patients face uncertainties in accessing off-label treatments used within the standard-of-care due to limited inclusion of rare disease considerations in the compendia that payers generally rely on. The rarer the disease, the less likely it is that medically accepted treatments will be published in compendia. Patient access programs are not generally available since a manufacturer offering free or discounted drug in this patient population would face off-label promotion scrutiny and potential liability. This leaves patients with few options unless they receive care from a provider willing to navigate the reconsiderations and appeals processes.
- Receiving care in the home through telemedicine is often the best option for low-income and rural patients and their families. Social determinants of health can,

however, impede availability of this option due to lack of broadband internet capabilities and financial impediments to maintaining reliable housing and utilities.

- We suspect that the unduly lengthy journey from emergence of symptoms to diagnosis is even longer for patients in communities of color and other underserved populations. Unfortunately, our member organizations do not have the data to quantify those inequities or identify clear causative factors.
- Patients and caregivers have faced significant challenges in accessing care throughout the pandemic and have often taken on more demanding and active roles as the hands and eyes of clinicians. With guidance, tools and support, families can take on proactive and impactful roles and responsibilities that optimize patient care.
- Haystack believes that technology can be leveraged to reduce the diagnostic journey for rare and ultra-rare disease patients as well as to ensure that all patients have access to the expertise needed to effectively treat or manage their condition.
- In rare disease patients, subtle changes in disease symptoms and/or progression could have profound impacts on longer-term outcomes. Encouraging plans to deploy wearables, monitors, and layperson friendly medical equipment would enhance remote monitoring capabilities and provide key patient information that may not be ascertained from periodic in-person visits,

Conclusion

Once again, Haystack and its member organizations appreciate the opportunity to submit comments as CMS finalizes the NBPP for calendar year 2024. We look forward to working with the Agency as it continues to refine ACA marketplace policies.

If you have any questions or would like to discuss the issues raised in our comments, please contact our policy consultant, M Kay Scanlan, JD at (410) 504-2324.

Very truly yours,







January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

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

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments regarding the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) proposed rule entitled “HHS Notice of Benefit and Payment Parameters for 2024.” The proposals outlined in this notice greatly affect the lives of those living with Multiple Sclerosis (MS) and their access to high-quality healthcare.

MS is an unpredictable disease of the central nervous system. Currently, there is no cure. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. An estimated 1 million people live with MS in the United States. Early diagnosis and treatment are critical to minimize disability. Significant progress is being made to achieve a world free of MS

The Society, founded in 1946, is the global leader of a growing movement dedicated to creating a world free of MS. The Society provides global leadership and funds research for a cure, drives change through advocacy, and provides programs and services to help people affected by MS live their best lives. To fulfill this mission, we fund cutting-edge research, drive change through advocacy, facilitate professional education, collaborate with MS organizations around the world, and provide services designed to help people affected by MS move their lives forward. Additionally, the Society sees itself as a partner to the government in many critical areas. While we advocate for the government’s involvement in accelerating the discovery, development, and delivery of new treatments, we do it as an organization whose research investment exceeds \$1 billion to date.

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

One M Street, SW Suite 510 Washington, DC 20003 **tel** 1-202-408-1500 **nationalMSsociety.org** **Together We Are Stronger.**

consumers. Requiring plans to adhere to uniform cost-sharing parameters promotes informed decision-making, reduces consumer confusion, and makes it easier to draw meaningful comparisons based on variables such as plans' premiums and network composition and design. Additionally, standardized plans can reduce cost barriers to care through a consumer-friendly structure (e.g., exempting services from the deductible, favoring copays instead of coinsurance). Moreover, standardized plans can promote 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 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. 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.¹ This environment favors the sophisticated insurers whose business it is to design health plans, at the expense of consumers who must expend time and resources to decipher among them. 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. The Society urges 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. However, as changes are made, it is important to enact safeguards. The first is to assure that plans that meet unique needs are not lost in this limit. If there is a legitimate need for a certain plan, it should be offered. The second is defining "meaningful difference" in a way that matters to patients. Setting a \$1,000 difference level may mean different things to different people, particularly to those who live with chronic diseases and disabilities. The Society urges HHS to meet with patients when developing any new "meaningful difference" standard.

With respect to the design of the standardized plans, we understand and appreciate HHS'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. The Society urges HHS to consider expanding the services and treatments that are not subject to deductibles. 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 Tier 3 and specialty tier drug coverage can be provided pre-deductible within actuarial value and other common constraints. As those living with MS rely on more expensive and specialty drugs, we ask that you adopt similar design approaches.

The Society applauds 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. We believe that this policy will ensure that

¹ 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.

generics and lower-cost alternatives to brand-name drugs are available for patients and that the savings that these medications provide are passed along to patients at the pharmacy counter.

Network Adequacy

It is essential that federal protections are designed to ensure that marketplace enrollees have timely, meaningful access to care and services. Additionally, enrollees must have access to accurate information that enables them to understand plans' networks and identify the plans and providers most likely to meet their needs. These protections are vital to those living with MS as access to care is essential for accurate diagnosis and preventing disease progression. The Society thanks HHS for adopting a rigorous, quantitative approach to evaluating network adequacy and supports the requirement that marketplace plans satisfy time and distance standards for network sufficiency as well as the implementation of 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. The Society also strongly supports the commitment to ongoing and proactive oversight of plan networks and urges HHS to test plans' compliance with the new appointment wait time standards during the year.

As HHS considers how to further improve network oversight, the Society encourages the scrutinization of networks' ability to provide culturally and linguistically competent care as well as physically and programmatically accessible care as, currently, network adequacy standards vary greatly between states. This should include, among other things, a rigorous assessment of whether a network includes sufficient providers who provide culturally appropriate care that is attuned to traditionally underserved communities (e.g., people of color, those living with disabilities, rural populations, and LGBTQI+ individuals) 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. Additionally, we ask HHS to rigorously assess the accessibility of provider offices and medical diagnostic equipment. To enable consumers to identify the plans and providers likely to meet their needs, marketplace plans must be required to indicate, in regularly updated provider directories, the languages spoken by a provider and/or their staff as well as the accessibility of the office. These directories should also clearly specify the telehealth capabilities of participating providers.

The Society supports the proposal to remove the exemption for plans without a network and the requirement that all marketplace plans 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, will make it easier for consumers to compare their marketplace plan options, and may reduce enrollees' exposure to high cost-sharing.

Health Plan Marketing Names: Oversight and Standardization

There has been a significant increase in the number of plans sold through [HealthCare.gov](https://www.healthcare.gov) with lengthy 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, HHS proposes to adopt specific regulatory language that requires marketing names to include correct information without omission of material fact, to not be misleading, and to undergo review during the annual plan certification process. We appreciate the attention to this growing problem and support the commitment to, in collaboration with state counterparts, reviewing all plan names during the certification process. As regulators conduct these reviews, the Society urges a focus on ensuring that marketing names are accurate and succinct.

Finally, to reduce confusion and aid consumer decision-making, we urge HHS to establish a standardized format for marketing names. Standard names should include basic and limited information about the plan: the insurer, metal level, and a non-misleading identifier for the plan's network. All other plan features should be immediately viewable on the plan's preview display on [HealthCare.gov](https://www.healthcare.gov).

Navigators: Door-to-Door Enrollment Assistance

Navigators play a vital role in educating the public about their coverage opportunities through marketplaces/public programs and in 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 (PHE) comes 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 Society shares HHS's commitment to reducing barriers to healthcare access and believes that this is of particularly high priority considering the forthcoming end of Medicaid continuous coverage. We agree that the flat prohibition on door-to-door enrollment assistance inhibits coverage take-up and appreciate the various efforts HHS has already undertaken to mitigate security and privacy risks for consumers. The Society is cognizant that unsolicited contacts are a longstanding method used to perpetrate fraud and other scams on consumers. If this proposal is finalized, we strongly urge the adoption of additional steps to minimize these risks. This includes additional training for Navigators and targeted outreach to the communities whose members will be solicited. It is also necessary to put in place 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

The Society believes the Navigator program would be further strengthened by the reinstatement of community- and consumer-focused program requirements that were previously eliminated when Navigator funding was scarce. We suggest that marketplaces once again be required to have at least two Navigator entities, at least one of which must be community-based, 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 as this conduct is contrary to their consumer assistance responsibilities.

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

The Society supports the proposed changes to facilitate and improve oversight of agents, brokers, and web brokers; 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 (i.e., short-term limited duration products) during marketplace open enrollment. HHS 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 screen consumers for Medicare and Medicaid eligibility so that individuals who qualify for such coverage are not routed to private insurance products. In addition, given the risks posed by their financial conflicts, agents and brokers should also be required to disclose 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 Society supports the proposed annual re-enrollment changes. With respect to the first proposal: we agree that allowing automatic re-enrollment of CSR-eligible bronze enrollees into lower (or equivalent) premium silver plans will improve affordability for these individuals. 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: the Society continues to urge HHS 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. This is especially true for those living with chronic diseases who need access to specialists. We appreciate and support the proposal to modify the re-enrollment hierarchy to preference plans with networks most like 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, it is certainly the case that an automatic re-enrollment system that permits the re-enrollment of individuals into a plan with zero net premium would promote coverage retention by reducing cost and administrative barriers. However, while the Society believes that 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 Kaiser Family Foundation estimates that between 5.3 million and 14.2 million people will lose Medicaid coverage during the 12-month unwinding period.² As we anticipate the end of the PHE, the Society thanks HHS for proposing changes to the special enrollment period (SEP) and agrees with the justifications presented for adopting them. However, we ask HHS to clarify that all marketplaces, state-based marketplaces, and the federally facilitated marketplace alike, may implement these consumer safeguards under existing authority.

Additionally, 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 the 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, HHS proposes to give marketplaces the option of greater flexibility over effective dates. HHS also 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 reestablish eligibility for public coverage and, if unsuccessful, enroll in a marketplace plan.

² Williams, Elizabeth, Rudowitz, Robin, and Borallo Bradley. 'Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirements During and After the PHE Ends.' Kaiser Family Foundation. 10 May 2022. <https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicaid-continuous-coverage-requirement-during-and-after-the-phe-ends/>. (Accessed January 30, 2023).

The Society strongly urges HHS to accelerate the implementation of its plans for HealthCare.gov so that consumers who lose coverage in 2023 may benefit. We thank HHS for announcing a temporary Exceptional Circumstances Special Enrollment Period from March 31, 2023 – July 31, 2024, for those who lose coverage during the Medicaid continuous coverage unwinding. Consumers who lose Medicaid during the unwinding may face numerous additional administrative hurdles and we believe these circumstances warrant affording consumers more time to understand and navigate their options.

Special Enrollment Periods: Mid-Year Changes to Plan Networks

The Society supports the proposal to provide a SEP to consumers whose providers leave their network mid-year. As we have discussed above, access to an adequate network is essential to those living with MS, 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 a 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 as this is a protection that already exists in Medicare Advantage.

Essential Community Providers (ECPs)

The Society appreciates that HHS continues to work to assure that networks include significant numbers of ECPs. Specifically, the 2024 NBPP would ensure that more mental health facilities and substance abuse disorder treatment centers are in networks. The newly created ECP categories will ensure more access to these critical services and allow HHS and advocates to better understand the scope of engagement of mental health and substance abuse treatment services in networks. Likewise, networks are required to include more federally qualified health centers and family planning providers.

Income Attestation for Premium Eligibility

The Society supports streamlining the process to determine if a patient is eligible for subsidies as this will help make sure that those who are entitled to assistance affording coverage can get it. If no tax data is available for an individual, using the income information attested to in an application will help more people who are eligible access subsidies.

Thank you again for the opportunity to provide comments on this proposal. If you have any questions, please contact Nicole Boschi, Director, of Regulatory Affairs at nicole.boschi@nmss.org.

Sincerely,



Bari Talente, Esq.
Executive Vice President, Advocacy and Healthcare Access
National Multiple Sclerosis Society



January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

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

Dear Administrator Brooks-LaSure:

Community Catalyst submits these comments in response to the Center for Medicare and Medicaid Services (CMS) Notice of Benefit and Payment Parameters for 2024 Proposed Rule (CMS-9899-P).

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why we work every day to ensure people's interests are represented wherever important decisions about health and healthcare are made: in communities, state houses, and on Capitol Hill. We share your goals of making the healthcare system work for those not currently well-served, especially people of color, individuals with low incomes, older adults, and those with chronic conditions or disabilities.

Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

Exchange Blueprint Approval Timelines (§ 155.106)

We support the proposed change to the timeline for Exchange Blueprint approval for states transitioning from a federally-facilitated Exchange (FFE) to a State-based Exchange on the Federal Platform (SBE-FP) or to a State-based Exchange (SBE), or from an SBE-FP to an SBE. We agree that the current timeline does not provide adequate opportunity for states to finalize and submit its Exchange Blueprint or work with HHS in ensuring readiness. Moreover,

additional flexibility in finalizing and submitting such changes would provide greater opportunity for stakeholder engagement, ensuring that state plans are structured in a way that best meets the needs of current and potential marketplace enrollees.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

Repeal of Prohibitions on Door-to-Door and Other Direct Contacts

In general, we support the proposal to repeal prohibitions against Navigators, certified application counselors, non-Navigator assistance personnel in Federally-facilitated Exchanges (FFE), and other assistance personnel in State-Based Exchanges (SBEs) from using unsolicited means of direct contact (i.e., door-to-door visits) to help consumers fill out applications or enroll in health coverage. Repealing these restrictions would better enable assisters to reach more potential enrollees, including those who stand to lose Medicaid or Children's Health Insurance Program (CHIP) coverage as states continue eligibility redeterminations.

However, we are concerned that without additional protections in place, eliminating this prohibition could expose consumers to possible scams by unauthorized or fraudulent actors who may steer people toward junk insurance plans like short-term, limited-duration plans that do not comply with essential health benefit (EHB) requirements. Moreover, given that enrolling in coverage entails a discussion of financial and personally identifying information, it could also put potential enrollees at risk for identity theft or other criminal acts. As such, we recommend the addition of a number of safeguards including:

- A clear way for the public to identify legitimate assisters and a public education campaign about how to do so;
- Paper documentation to be left with the enrollee including the name of the assister and the assister's organization, any transaction that occurs and how to cancel the transaction or make changes;
- Additional training and resources to help assisters identify the household member who can appropriately consent to enrollment and provide financial and household information.

Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220)

We support the proposed changes to implement new requirements and consumer protection standards for agents, brokers, and web-brokers that assist consumers with enrollments through FFEs and SBE-FPs. Specifically, we agree with HHS's proposed changes at § 55.220(g)(5)(i)(B) and § 155.220(h)(3) to provide HHS more time to review suspension rebuttal evidence and termination reconsideration requests that agents, brokers, and web-brokers submit to HHS.

Allowing HHS 45 calendar days to respond to evidence that agents, brokers, or web-brokers submission of rebuttals to allegations of fraud or abusive, and sixty calendar days to review cases of licensure non-compliance is appropriate given the complexity of such inquiries.

We also support the proposed changes requiring agents, brokers, and web-brokers to document that applicants' eligibility information has been reviewed by, and confirmed to be accurate by, the applicant or their authorized representative before the application is submitted as well as the proposed change that the consumer, or their authorized representative, has to take an action, such as providing a signature or recorded verbal confirmation, to document the consent.

However, while we appreciate these efforts, we reiterate the need for additional actions. HHS should prohibit agents and brokers that sell QHPs from marketing products that are not compliant with the ACA's individual market reforms during open enrollment. The Department should also consider requiring agents and brokers to screen consumers for Medicare and Medicaid eligibility, so that individuals who qualify for such coverage are not routed to private insurance products. In addition, agents and brokers should be required to disclose the amount of their commissions to their consumers, so that individuals can understand financial incentives may influence their broker's recommendations.

Eligibility Standards (§ 155.305)

Failure to File and Reconcile Process (§ 155.305(f)(4))

We support HHS's efforts to promote continuity of coverage, encouraging compliance with the filing and reconciling requirement, minimizing the potential for Advance Premium Tax Credit (APTC) recipients to incur large tax liabilities over time and avoiding situations where enrollees become uninsured when their APTC is terminated.

We support the proposed change to only determine an individual ineligible for APTCs after two consecutive tax years due to the delays in filing allowed by IRS and by general delays in IRS information. This change will help ensure that people are not terminated for non-filing when they may actually still be within a filing period or because the IRS has not yet processed timely submitted information.

We also agree with HHS that additional outreach is needed to both enrollees and tax preparers about the failure to file and reconcile process and the risk of noncompliance. Understandable and accurate information about the process for determining eligibility is critical to avoid unnecessary coverage losses and ensure that affordable coverage remains available to as many people as possible.

Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

We support HHS's proposal to require marketplaces to accept an applicant's or enrollee's attestation of projected annual household income when the marketplace requests IRS tax return data but IRS indicates such data is not available. We also support HHS's proposal to provide those with data matching issues additional time to provide documentation. Data matching issues leave many people to pay the full premiums to their issuer after the end of an inconsistency period and during an appeal process. For consumers initially determined eligible for APTCs, this

can create an extreme financial hardship and puts these consumers in a bind of maintaining coverage with full premiums versus losing coverage and potentially incurring medical debt, especially if coverage is allowed to lapse for an extended period of time.

Annual Eligibility Redetermination (§ 155.335)

We appreciate HHS's recognition of the need for an automatic re-enrollment mechanism, given that some people do not actively return to the marketplace to make plan choices during open enrollment and that the current process for re-enrollment may keep people in plans that are more expensive than necessary. We support the new re-enrollment hierarchy for enrollees who would otherwise be automatically reenrolled in a bronze-level QHP without Cost Sharing Reductions (CSRs), to instead be automatically reenrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium. Moreover, we support the proposal to prioritize maintenance of similar provider networks where possible, especially given the risk for medical debt that unintended receipt of out-of-network care poses.

In general, we also support HHS' proposals for future years to prioritize reenrollment in plans that would result in reduced total out-of-pocket costs throughout the exchange re-enrollment hierarchy. These changes would help ensure that enrollees who are not eligible for CSRs and whose plans are no longer available are automatically re-enrolled in a plan that offers more generous coverage and total out-of-pocket costs that are the same or lower than their previous plan. However, we are concerned that establishing this revised hierarchy using a single variable (total out-of-pocket costs) could result in some enrollees being re-enrolled in plans with higher-than-expected premiums. We therefore recommend treating net premiums and anticipated cost-sharing as separate variables to prevent situations in which an enrollee is unable to pay premiums after being auto-enrolled into a different plan than the one they originally selected.

We strongly support HHS's proposal to automatically re-enroll individuals who are behind on their premium payments or who have failed to remit a binder payment into a QHP with a zero-dollar net premium. These proposals would be particularly helpful for individuals who initially select a plan with a zero-dollar net premium, but do not return to the marketplace during open enrollment to ensure that their premium has not increased.

For each of these policies that HHS chooses to enact, we encourage HHS to establish a special enrollment period (SEP) for anyone who is automatically re-enrolled into a different plan than the one they originally selected. Currently, an SEP is available for enrollees who are automatically re-enrolled because their plan is discontinued; we believe that individuals who are automatically re-enrolled into new plans for financial reasons should have the same opportunity.

Special Enrollment Periods (§ 155.420)

Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

We strongly support the proposed change to give marketplaces the option to offer earlier coverage effective start dates for consumers with a future loss of minimum essential coverage (MEC). This will help individuals who lose non-Marketplace coverage mid-month avoid a gap in coverage before their Marketplace coverage is effectuated. As states continue Medicaid and CHIP redeterminations, this will certainly help individuals in states that terminate Medicaid and CHIP coverage mid-month and ensure that people are able to continue to access the care they need.

Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

We strongly support extending the sixty-day SEP resulting from loss of Medicaid or CHIP from sixty to ninety days as it essential to mitigating gaps in coverage during the unwinding of continuous coverage requirements previously tied to the COVID-19 Public Health Emergency (PHE). However, we urge HHS to make the ninety day SEP mandatory. Federal rules already provide marketplaces broad authority to grant SEPs under “exceptional circumstances”¹ and this allowance should not be undermined. We also object to delaying implementation of the extended SEP to January 2024. Given that the Consolidated Appropriations Act of 2022 has delinked continuous coverage requirements from the PHE and allows for eligibility redeterminations to begin April 1, 2023, millions of Medicaid and CHIP enrollees could face termination of coverage well before January 2024.

Plan Display Error Special Enrollment Periods (§ 155.420(d))

We support HHS’s proposal to provide an SEP to consumers who encounter a material error related to plan benefits, service area, cost-sharing, or premium. However, we encourage HHS to take all necessary steps to prevent such errors from happening in the first place.

We also strongly support HHS’s consideration to implement an SEP for consumers whose providers leave their network mid-year and encourage HHS to establish this policy in future plan years in a way that holds consumers harmless for the cost of out-of-network services prior to transitioning to a new plan during such an SEP.

Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

Standardized Plan Options (§ 156.201)

We applaud HHS’ continued efforts to strengthen standardized plan for plan year 2024 and beyond. We strongly support the proposed changes to require issuers in the federally facilitated exchanges and state-based exchanges that use the federal platform to offer at least one standardized plan at every product network type, metal level, and in every service area where the issuer also offers non-standardized plans.

¹ 45 C.F.R. § 155.420(d)(9).

According to HHS’ own research, “almost three quarters of HealthCare.gov consumers have more than 60 plan options to choose from, and the average number of plans is over 100.”² This complex landscape of plan options can lead to confusion among shoppers and errors during plan selection. Choice overload may lead consumers to make plan selections without regard to value and discourages consumers from switching from lower-value plans to higher-value plans.

This proposed change will better enable consumers to make apples-to-apples comparisons of plans sharing a common benefit and cost-sharing structure. The ACA generally achieved common benefit structure across plans through the requirement that Marketplace plans cover EHB, but lack of cost-sharing standardization has allowed issuers to offer an unlimited number of plans across the different Marketplaces. Through the standardization proposal, consumers can compare plans without regards to cost-sharing requirements, allowing individuals to focus on other factors that are better indicators of the plan’s value and that are more crucial to consumers’ health, such as premiums, provider network, and quality of services.

Standardization also serves as a tool to improve affordability and address health disparities in marketplace coverage. HHS’s proposal will ensure that consumers always have access to at least one plan that exempts certain essential services, including emergency room services, primary care visits, and mental health and substance use disorder treatment, from deductibles. Black, Hispanic, and other people of color as well as people with disabilities and Tribal communities often lack access to such services that are key to prevent further health complications. As such, exempting these services from the deductible in all standardized plans will make it easier for these communities to receive the care they need and help close gaps in access to care.

However, we once again urge HHS to include standardized cost-sharing for pediatric dental services in the standardized options for 2024 and beyond. This would present the greatest opportunity for children enrolled in marketplace coverage to receive the full range of EHB coverage, as standardized options have been relatively popular among marketplace consumers. Pediatric dental coverage remains one of the more complex aspects of marketplace coverage for consumers as it may be offered separately or as part of a QHP.

While the proposed rule would make improvements to transparency in plan information, it remains difficult for families to compare covered services, cost-sharing structures, and deductible applicability for pediatric dental services because QHPs do not always provide the same level of benefit information as stand-alone dental plans. Standardized options make plan selection easier for consumers and facilitate federal and state review, approval, and oversight and this should be inclusive of all EHB services. Furthermore, inclusion of pediatric dental services is unlikely to significantly increase QHP actuarial values. Research indicates that, on average, the portion of the premium allocable to pediatric dental is low compared to stand-alone dental

² U.S. Dept. of Health & Human Svcs., Assistant Sec’y for Plan. and Evaluation (“ASPE”), Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces 1 (2021), <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

plan premiums within the same marketplace, and that most consumers are likely to experience lower out-of-pocket costs when pediatric dental services are included in a QHP.³

Non-Standardized Plan Option Limits (§ 156.202)

We further support HHS's proposal to establish a numeric limit on the availability of non-standardized plans. However, we recommend that HHS also require a meaningful difference in non-standardized plan offerings by reinstating the standard previously codified at 45 C.F.R. § 156.298. This would limit the volume of nearly similar plans so that consumers can readily compare plan, and also ensure that consumers have real choices when selecting a plan.

Moreover, evidence shows that outreach efforts are also necessary in helping consumers compare plans and avoid choice errors. A Covered California analysis found that nearly 20,000 Covered California consumers selected more expensive gold and platinum plans in 2019 despite being eligible for a less expensive enhanced silver plan with richer benefits.⁴ Underscoring the critical role of robust consumer assistance, Covered California engaged in significant outreach to these consumers describing the financial savings if they switched to the silver product, resulting in about 20 percent of these individuals switching to a silver plan with lower premium and cost-sharing. HHS should therefore require marketplaces to implement a multi-pronged approach to helping consumers navigate the platforms to make sound plan selections.

QHP Rate and Benefit Information (§ 156.210)

Age on Effective Date for SADPs

We support HHS' proposed change to require issuers of stand-alone dental plans (SADPs) to use an enrollee's age on effective date as the sole method to calculate an enrollee's age for rating and eligibility purposes for PY2024 and beyond. We agree that standards for QHPs and SADPs should be aligned wherever possible, including rating methodologies as doing so reduced confusion among potential enrollees.

Guaranteed Rates for SADPs

We also support the proposed change to require SADPs to submit guaranteed rates as a condition of certification, whether sold on or off the exchanges. Guaranteed rates are one of the many tools in the toolbox for protecting people against unexpected costs and ensuring that people are able to make informed decisions when shopping for their health coverage; this should be no different for dental coverage when purchased separately from a QHP, which is the only option for some consumers. Moreover, because the portion of APTC attributable to pediatric dental coverage can now be applied to SADPs, after-purchase rate information changes could affect APTC calculation, resulting in unnecessary financial burden and uncertainty for enrollees selecting SADPs for their children.

³ Vujicic M, Yarbrough C, Nasseh K. The effect of the Affordable Care Act's expanded coverage policy on access to dental care. *Med Care*. 2014;52(8):715-719.

⁴ Andrew Feher & Isaac Menashe, Using Email and Letters To Reduce Choice Errors Among ACA Marketplace Enrollees, *Health Affs*. 812, 814 (May 2021), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02099>.

Plans That Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

We applaud HHS's decision to amend clarify that only plans that use networks may participate in the marketplace. Non-network plans have historically presented a barrier to people's ability to access care and control their health care costs and they unnecessarily expose people to potential medical debt. We agree with HHS' understanding that most people prefer plans that use a network, whether a health or dental plan. Plans with networks better enable people to understand which providers are covered under their plan.

We also encourage HHS to take additional action to ensure that QHPs and SADPs are complying with existing network adequacy standards. We appreciate HHS's continued efforts to strengthen network adequacy standards but enrollees continue to encounter network adequacy issues across a range of services, including behavioral health and dental care. As such, more vigilant enforcement is warranted to ensure that marketplace plans are providing appropriate access to all covered services.

However, we oppose HHS' proposal to provide a limited exception to the network requirements only for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers, especially given that HHS does not propose to extend this exception to QHPs who are likely to draw from the same pool of dental providers or even contract directly with an SADP issuer to offer pediatric dental coverage – whether by requirement or by choice. And while it may be uncommon for exchanges to require QHPs to offer pediatric dental coverage when no SADP is available, state exchanges like AccessHealthCT have established pediatric dental coverage requirements in other manners and states have previously interpreted §1302(b)(4)(f) of the ACA to require QHPs outside of the exchanges to include pediatric dental coverage. We agree that dental provider availability is a concern, especially in rural areas but we urge HHS to pursue policies that aim to close gaps in access to dental providers rather than allowing insurers, regardless of type, to avoid responsibility in ensuring access to the services their members pay for.

Essential Community Providers (§ 156.235)

We applaud HHS' continued efforts to increase participation of Essential Community Providers (ECPs) who are critical in ensuring access to care, especially for Black, Hispanic, and other people of color, people with low-income, people with disabilities, Tribal communities, rural communities, and other underserved population. ECPs are important to improving health outcomes and advancing health equity for these communities who face the steepest barriers to accessing the care they need.⁵

Specifically, we support HHS' proposal to add Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers as stand-alone ECP categories beginning in FY 2024. We

⁵ Cristina Jade Peña et. al., Kaiser Family Found., Federal and State Standards for “Essential Community Providers” under the ACA and Implications for Women’s Health (2015), <http://files.kff.org/attachment/issue-brief-federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health>.

support this proposal. Millions of people in the United States have a behavioral health condition, but do not receive the care they need. More than one in five adults (57.8 million people) have a mental health condition, while an estimated 46.3 million adolescents and adults live with a SUD. Despite the prevalence of these conditions, people with behavioral health conditions struggle to find care. Over half of people with a mental health condition did not receive any care. Only 6.3% of individuals ages twelve or older who needed SUD treatment in the past year received it.⁶

Due to systemic racism and discriminatory policies, the disparities in access to mental health services are especially stark. For example, American Indians and Alaska Natives and Black people access mental health services at substantially lower rates than their white counterparts.⁷ Moreover, during the COVID-19 pandemic, there have been sharp increases in the prevalence of mental health conditions in specific populations, including: young adults; Black, Hispanic, and other people of color; essential workers, and unpaid caregivers.⁸ People with mental health conditions also frequently report access barriers related to finding behavioral health providers, even when they have insurance, forcing many to forego care or incur higher costs for out-of-network providers.⁹ Therefore, we support HHS's proposal to create standalone ECP categories for SUD Treatment Centers and Mental Health Facilities to improve access to care for these populations.

We also support the proposal to incorporate the Community Mental Health Center (CMHC) provider type into the Mental Health Facilities ECP category. However, it would be helpful to further define what other types of providers beyond CMHCs might fall in the ECP Mental Health Facilities Category. Similarly, we urge HHS to further define what types of treatment facilities can fall into the SUD Treatment Center category. Given the wide variation in quality and scope of services offered by SUD providers, it is important QHPs be required to fulfil their obligations by contracting with high-quality providers. At a minimum, this SUD providers in this category should provide Medication Assisted Treatment (MAT), either on site or through referral.

With regard to Federally Qualified Health Centers and Family Planning Providers, we support the proposal to require QHPs to contract with at least thirty five percent of available providers in these categories that qualify as ECPs in the plan's service area. We also support HHS's decision to continue to treat multiple providers at a single location as one ECP, and to require QHPs with tiered networks to meet the ECP threshold in the lowest cost-sharing tier.

⁶ Substance Abuse & Mental Health Servs. Admin., Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health 39, 46 (2022), <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf>.

⁷ Azza Altiraifi & Nicole Rapfogel, Ctr. for Am. Progress, Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis (Sept 10, 2020), <https://www.americanprogress.org/article/mental-health-care-severely-inequitable-came-coronavirus-crisis/>.

⁸ Ctrs. for Disease Control & Prevention, Morbidity and Mortality Weekly Report: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf>.

⁹ Azza Altiraifi & Nicole Rapfogel, Ctr. for Am. Progress, Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis (Sept 10, 2020), <https://www.americanprogress.org/article/mental-health-care-severely-inequitable-came-coronavirus-crisis/>.

Thank you for this opportunity to comment on these proposals. We look forward to supporting you as thought-partners as you continuously develop effective and impactful policies. For additional questions or information, please contact Colin Reusch at: creusch@communitycatalyst.org.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Emily Stewart". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Emily Stewart
Executive Director
Community Catalyst



January 30, 2023

Submitted electronically

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016, Baltimore, MD 21244–8016

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024

HealthSherpa appreciates this opportunity to provide comments on the Proposed Notice of Benefit and Payment Parameters (NBPP) for 2024. The views and positions expressed in this comment letter are HealthSherpa's alone, and do not necessarily reflect the views and positions of our clients, investors, or partner entities.

Background and History

HealthSherpa's enrollment platform is currently used by dozens of large employers, insurers, and nonprofits, in addition to over 45,000 Marketplace certified agents and brokers. Since 2014, HealthSherpa has enrolled over 13 million consumers in Marketplace coverage, including more than 4 million enrolled during the 2023 Open Enrollment Period (OEP). This represents a significant portion of Healthcare.gov's 12.2 million enrollments in OE2023, making HealthSherpa the largest private enrollment channel for Federal Marketplace coverage by a substantial margin.

Documenting Receipt of Consumer Consent (§ 155.220(j))

We applaud CMS' goal of ensuring consumer consent is obtained before enrollment in a qualified health plan, and to improve the resolution process when there are disputes regarding whether consent was obtained and by whom. However, we note that true fraud is a relatively rare problem in the Marketplace, and we are concerned that blocking a consumer from enrolling until they've taken an action to produce a consent record will harm vulnerable consumers and, if done in an overly burdensome way, substantially impact enrollment volume.

Actively obtaining documentation of consent from a client can be challenging and introduces significant friction into the enrollment process. While asking a client to sign a consent form in person might seem trivial, most Marketplace business is conducted over the phone, meaning that a client must either consent verbally on the phone or take an action (e.g. click a button indicating consent, respond to a message, print and sign a form) in real time via a medium such as email or SMS. Each of these approaches has its own downsides.

- Taking an action via email requires reliable access, which is unequally distributed among marketplace enrollees. According to ASPE as of 2019, 1 in 6 low-income Americans had

no internet access, and the problem is particularly acute in rural communities and among older persons.¹ Older consumers, in particular, frequently can't immediately access their emails due to forgotten passwords or unfamiliarity with digital devices. Waiting for a client to go check their email significantly slows down the enrollment process, reducing the number of clients an agent can serve. Alternatively, if an agent instructs a client to take an action and call back later, many clients simply won't call back and finish the process, or may give up after waiting hours on hold (more than 20% of enrollees enroll during the week before the December 15th deadline for 1/1 coverage, leading to bottlenecks.)

- Due to the Telephone Consumer Protection Act, a consumer must explicitly take action to opt in to receive SMS messages. This limits the utility of SMS as a channel for distributing a link to fill out a consent form. Also, similar to email, there is likely a higher proportion of the population we serve that might not have access to a smartphone or may be unfamiliar with how it works.
- We know from working with consumers who lack internet (and so must mail in documents to Healthcare.gov) that printing and sending forms is extremely laborious for the average Marketplace consumer. Many simply will not end up completing the task.
- While recorded verbal consent in and of itself does not require the audio recording of Personally Identifiable Information (PII), conversations around Marketplace enrollment naturally involve a great deal of sensitive information, creating the risk of improper storage of PII. As such, it is a best practice to use HIPAA-compliant platforms to store any call recordings with clients. Setting up such systems may be feasible for large, sophisticated agencies, but for smaller independent "mom and pop shops" (who represent a substantial share of ACA brokers) the cost and effort involved with setup and maintenance of such systems may lead to widespread noncompliance or dissuade them from offering Marketplace enrollment services altogether, in favor of simpler (but low-value) products with larger margins such as short term health insurance.

In general, we find that adding even trivial steps to the enrollment process - for example, a new interstitial screen to click through - can impact conversion by around 5%. More difficult tasks - for example, answering Experian questions about identity proofing - have a drop-off rate exceeding 10%. We would expect that drop-off from a digital consent process would be closer to the higher, 10% rate - to address a problem which, based on recent review of HealthSherpa's complaint/fraud cases, affects less than 0.02% of applications (many of which are ultimately resolved with no evidence of fraud.)

After processing more than 13,000,000 enrollments, we have come to find that true fraud tends to follow clear patterns that can be programmatically identified (for example, a sudden high volume of enrollments, all with the same contact details, done by a new-to-the-market agent.) That said, if HHS moves forward with requiring consent, we would make the following recommendations:

¹ <https://aspe.hhs.gov/reports/low-income-internet-access>

- Instead of requiring consumers to take action during the application process, HHS should allow a “passive” approach, where consumers are given the ability to retroactively flag an application as fraudulent. For example, information about how to cancel an application could be included in follow-up communications sent to the enrollee. This would ensure consumers aren’t blocked from enrolling - particularly during key deadline days, when calling an agency back after locating a consent email might mean an hours-long hold time, which leads to consumers not completing the enrollment process.
- In the absence of a passive process, HHS should exercise enforcement discretion to allow agents and brokers time to establish appropriate consent procedures. This will minimize impacts on enrollment for the PY2024 OEP. Since this will be the last OEP before the American Rescue Plan subsidy expansions expire, we’d want to ensure that as many people as possible can enroll and take advantage of expanded subsidies.
- HHS should maintain a flexible approach to the medium of consent (e.g. written, verbal, digital) as proposed. Flexibility will be key to making consent procedures as easy as possible for hard-to-reach populations.
- HHS should maintain the requirement that the responsibility of gathering consent rests with the individual broker. This will ensure that brokers have the flexibility to use consent procedures that will be minimally disruptive to their population.

Providing Correct Information to the FFEs (§ 155.220(j))

We applaud CMS’ goal of ensuring information submitted to the Exchanges is accurate, so that consumers receive correct APTC determinations and do not unnecessarily generate data matching issues. However, we believe that requiring a consumer to attest that they have reviewed the information on the application, and that it’s accurate, creates opportunities for the leakage of personal information. Additionally, this will add significant friction to the enrollment process and may cause a substantial drop in enrollment volume.

As discussed above relating to consent, most Marketplace enrollment business is not conducted in person. That means that creating an auditable paper trail indicating that a consumer reviewed and verify the accuracy of the information on an application would involve one of two approaches:

- The broker records the entire call with the client, including a verbal confirmation that the information the client has shared is accurate. This creates a risk of PII leakage and significant burden around appropriate storage of sensitive recordings, which will increase the cost and logistics of doing Marketplace business and reduce agent incentives to participate in the ACA market (vs selling other products such as short term.)
- The consumer logs into an account to view the information and takes action to confirm that it is accurate. This represents a significant time and logistical burden for enrollees, especially those who lack internet access or are not digitally literate.

If both the consent requirement and requirement to verify the accuracy of information at 155.220(j) are finalized, we would advise that HHS allow these two functions to be performed simultaneously by the consumer to minimize time and logistical burden.

Income Inconsistencies (§155.320)

We support HHS' aim to support consumers in avoiding or resolving income Data Matching Issues (DMIs) and maintaining their coverage. As such, we strongly support HHS' proposal to require the Marketplaces to accept an applicant's attestation of annual income when the IRS has no income information available for the past 2 years. This will substantially reduce the rate of income DMI generation and thus allow more consumers to maintain their coverage.

We also support HHS' second proposal, to extend the time frame within which consumers may resolve an income DMI. Initial attempts to resolve income DMIs are often rejected due to insufficient documentation, meaning the consumer must resubmit. This shortens the timeframe for resolution and can cause individuals to lose coverage.

Non-standardized plan option limits (§156.202)

Of the two proposals to limit non-standardized plan options which HHS has proposed, we feel that the meaningful difference standard strikes a better balance between reducing choice overload and maintaining the ability for issuers to provide innovative plan offerings tailored to the needs of individual consumers.

We acknowledge that the number of plans offered on the Marketplace has grown substantially over the past few years, and that having to choose between a large number of plans can be difficult for the self-directed consumer. HHS writes that focusing solely on improving choice architecture on Healthcare.gov would not sufficiently address this issue given that more and more consumers enroll through alternative pathways, including through Direct Enrollment and Enhanced Direct Enrollment Partners. However, we note that an increasing number of applications— particularly those done through DE & EDE partners— are facilitated by brokers, who are better equipped to understand the available plan options and guide the consumer to the right choice.

Re-enrollment hierarchies (§155.335)

We are supportive of HHS' proposal to move CSR-eligible passive re-enrollees from bronze to silver plans, if the premium is lower or equivalent to the bronze plan they would have been crosswalked into. We are heartened to see that HHS proposes to factor network into this decision, given that in our experience, a major reason that enrollees forgo \$0 CSR silver in favor of a \$0 bronze plan is that they need a specific provider in network, and cannot afford the premiums for a silver plan with the same network.



Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b)) & Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

We are supportive of HHS' proposals to permit Exchanges the option to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC, and provide more time for consumers who lose Medicaid or CHIP to report their loss of coverage and enroll in Exchange coverage. These proposals will reduce coverage gaps and ensure smoother transitions to Marketplace coverage.

Request for Information: Payment HCC for Gender Dysphoria

We are supportive of the potential inclusion of gender dysphoria in risk adjustment models. This could add a much needed incentive for issuers to adequately cover gender affirming care.

Thank you again for this opportunity to comment on the NBPP for 2024. We look forward to continued partnership with HHS to help more Americans access quality, affordable health coverage.

Sincerely,

A handwritten signature in cursive script that reads "George U. Kalogeropoulos".

George Kalogeropoulos, CEO
HealthSherpa



January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

As the state primary care association (PCA), the Pennsylvania Association of Community Health Centers (PACHC) represents and supports the largest network of primary healthcare providers in the commonwealth. This network of health centers includes Community Health Centers (FQHCs and FQHC Look-Alikes), Rural Health Clinics and other like-mission providers serving more than 1,000,000 patients annually at nearly 400 sites in underserved rural and urban areas throughout Pennsylvania. We begin with a summary of our comments, and then address each in detail.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, FQHCs helped thousands of individuals seeking coverage in 2021. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. OUR ORGANIZATION strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

PACHC welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential

Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

PACHC supports CMS' proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. **PACHC** recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, PACHC recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As OUR ORGANIZATION has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. **PACHC** recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, **PACHC** believes that these good-faith contracts should extend to all FQHCs in their service area.

¹ Section 1311(c)(1)(C)

² <https://www.ghpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

PACHC recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers' continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like **PACHC**, to engage with states and hold them accountable. **PACHC** recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

PACHC strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. **PACHC** appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. **PACHC** appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

PACHC also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

PACHC also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations,

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person>.

⁶ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1>).

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

PACHC appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally Facilitated Marketplace.⁸ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

PACHC is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. [INCLUDE ANTICIPATED # OF REDTERMINATIONS FOR YOUR STATE] These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, PACHC they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. PACHC also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.¹² ^{13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

PACHC supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. **[INCLUDE SPECIFIC EXAMPLES OF ISSUES PATIENTS HAVE HAD WITH BROKERS, IF APPLICABLE]** For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

PACHC supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic).

When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, PACHC applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and PACHC also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. **PACHC** appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

PACHC also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. OUR ORGANIZATION appreciates CMS recognizing how administrative functions can impact

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

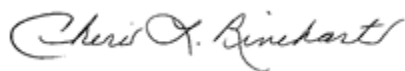
continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

PACHC recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection PACHC supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact Eric Kiehl, PACHC Director of Policy and Partnership at eric@pachc.org or 717-761-6443, ext. 206.

Sincerely,



Cheri Rinehart
President and CEO
Pennsylvania Association of Community Health Centers



January 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

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

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS') proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2024."

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable health care. Made up of more than 150 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

The NHC applauds CMS' commitment to "providing quality, affordable coverage to consumers while minimizing administrative burden and ensuring program integrity" and advancing health equity for consumers purchasing Marketplace coverage. We have, since the enactment and implementation of the Affordable Care Act (ACA), advocated for policy refinements that promote marketplace stability and

- Provide consumers with a robust set of plans and actionable, quality information to enable them to choose the plan that most suits their needs;
- Ensure comprehensive coverage, including network adequacy;
- Advance health equity; and
- Facilitate marketplace stability.

We particularly appreciate that many of the policy refinements within the Proposed Rule consider the needs of individuals with chronic conditions and disabilities for whom meaningful and affordable health coverage is essential to ensuring access to the health care they need at a cost they can afford.

Need for New Shopping Tools on Healthcare.gov

Many of the issues raised in the 2024 NBPP, such as limiting nonstandard plans and auto re-enrollment, focus on the need to ensure people are in plans that best meet their needs. This often is difficult for people to achieve given the current information and tools available to patients on Healthcare.gov. We encourage the Department to collaborate with patients and their representatives in the coming months and through the 2025 NBPP to continue to upgrade the shopping experience by refining Healthcare.gov's consumer support tools to better address the needs of people with chronic diseases and disabilities. Making available more specific information about total costs and coverage will ensure that all consumers have comprehensive information to help them make smart health care decisions.

In general, people shopping for health insurance need more information to better calculate their total cost of care (including premiums, deductibles, copays, and coinsurance) when shopping for and comparing plans. Shoppers need specific information around coinsurance (in exact dollar figures as opposed to a percentage), copays, and other costs. A tool to help people compare and sort by expected out-of-pocket expenditures in each available plan, based on their current medications, providers, and other health care usage, would be a significant advancement. In addition, we believe that Healthcare.gov is a tool that can be used to help educate shoppers. For example, if shoppers were presented with information about when it might make financial sense to choose a higher premium plan with a lower deductible and out-of-pocket limit, they would be more likely to consider that option.

Our specific comments on the 2024 NBPP are below.

Standardized Plans and Limits on Non-Standardized Plans

The 2024 NBPP introduces limits on non-standardized plans. There would be a limit of two non-standard plans per product and metal level. It also signals that CMS may consider a more stringent meaningful-difference standard. The NHC agrees with CMS that too many plan options can sometimes create confusion for patients. The improvements to consumer education and plan choice information referenced at the beginning of these comments would significantly help address this issue. As CMS considers any changes to the amount of available plans, it is important to have some safeguards. The first is assuring that plans that meet unique needs are not lost in this limit. If there is a legitimate need for a certain plan, it should be offered. This involves oversight and flexibility if necessary. The second is making sure to reflect costs beyond premiums such as out-of-pocket costs like co-insurance. We believe improvement to the meaningful-difference standard in a way that matters to patients can help reduce the number of plans to ease the shopping experience. We urge CMS to significantly engage patients in developing any new meaningful-difference standard.

In addition, the 2024 NBPP is requiring standardized plans include generic drugs in the generic tier 1 or specialty tier, if appropriate, and brand name drugs in the brand name tier 2 or 3 or specialty tier if appropriate. For most patients this will create a cleaner division and understanding of where their drug is covered. However, there can be significant variety in costs of generic drugs. We recommend that when a brand drug in a higher tier (i.e., tier 2, 3, or specialty) is less expensive than the generic, a patient should be able to access whichever drug is cheaper and pay the lesser amount.

Network Adequacy

Continuing to refine and enhance the networks of providers available to patients is an important part of ensuring that patients have accessible health care. The NHC appreciates that the 2024 NBPP refines network adequacy standards to better serve patients. We particularly commend CMS for:

- Implementing wait time standards, though we note this may require improvements to data sharing infrastructure to achieve this important goal;
- Continuing to require insurers to identify whether their in-network providers offer telehealth services; and
- Requiring all marketplace plans to use a network and comply with all network adequacy standards.

The NHC urges CMS to continue to monitor and assure network adequacy. Two specific recommendations for improving network adequacy include:

- Ongoing testing by CMS of network adequacy to assure that access aligns with the attested levels.
- Monitoring of provider directories and how they align with adequacy standards. The recent [RFI](#) on a national directory of health care providers & services was a helpful first step in exploring how we can take a different approach to provider directories to improve their accuracy. The NHC [response](#) to that RFI articulated the importance of comprehensive and up-to-date provider directories are to patients. Having quality provider directories will help monitor and assure quality network adequacy.

Essential Community Providers (ECPs)

The NHC also appreciates that CMS continues to work to assure that networks include significant numbers of ECPs. In our [2023 NBPP comments](#), we supported CMS efforts to increase the ECP threshold from 20 to 35 percent of available ECPs in each plan's service area. ECPs can play a critical role in ensuring access to care for vulnerable populations.

The 2024 NBPP continues this focus on increasing access to care in EHPs. Specifically, the 2024 NBPP would ensure that more mental health facilities and substance abuse

disorder treatment centers are in networks. The newly created ECP categories will ensure more access to these critical services and allow CMS and advocates to better understand the scope of engagement of mental health and substance abuse treatment services in networks. In addition, networks are required to include more federally qualified health centers and family planning providers.

In addition, and outside of the context of the NBPP, we continue to encourage CMS to strengthen the ECP system. Through the NHC's health equity work over the last several years, it has become clear that we need to work together to assure that ECPs are sufficiently supported and resourced to play the important role that we are asking of them. If they are going to be a resource to meet network adequacy standards, plans and the government must work together to make sure they have what they need to do that work.

Improved Oversight of Agents and Marketing

The provisions in the 2024 NBPP that provide greater oversight of those that sell plans and how plans are marketed are welcome. While agents are a critical tool in helping people access plans, patients can be misled too often. Several provisions in the NBPP are designed to protect patients and ensure that agents are acting correctly including:

- Requiring agents, brokers, and web-brokers to document that the eligibility information contained in a consumer's application has been reviewed by and confirmed to be accurate by the consumer; and
- Requiring agents, brokers, and web-brokers to document that they have received consent from the consumer to provide assistance in the first place; and
- Providing additional oversight of health plan marketing names.

The NHC appreciates CMS efforts to protect patients.

Automatic Re-Enrollment

In the 2024 NBPP, CMS proposes to give marketplaces the option to modify their re-enrollment hierarchy. Specifically, marketplaces would be able to automatically re-enroll eligible bronze plan enrollees in a silver plan with cost-sharing reductions (CSR) if they would save money and have access to a comparable network and services. It also incorporates the net premium and provider networks into the hierarchy more broadly. The NHC agrees that the majority of eligible people would be better served by a CSR plan. However, we caution against potential unintended consequences such as moving people to plans they do not want. For instance, they may have chosen a plan in order to access a specific provider that may not be in the network of their new plan. It is important that we undertake consumer education and plan choice information referenced at the beginning of these comments to better assure people are in the plans that best suit their needs.

CMS also solicits comments on a variety of other potential changes to auto re-enrollment in future years, including the possibility of automatically re-enrolling consumers:

- Into the lowest cost silver plan if they chose the lowest cost silver plan in the current year;
- Who are delinquent on their premium payments, into a new plan with no net premium after subsidies.

Much like the proposed changes in the hierarchy, these changes should be implemented to make sure that patients are best connected to plans that will be a better fit for them and save them money. However, it is critical that patients be informed and understand when and why these auto re-enrollments happen. The NHC urges CMS to create auto re-enrollment procedures that minimize disruption for patients. This means that patients should be fully informed about the reason for a plan change, and auto re-enrollment should not override active choice. For example, even if the silver CSR plan has the same breadth of provider network as their current plan, they may have an individual specialist who is currently in their network but not in the new plan that they are being auto re-enrolled into. It would be helpful if patients had the ability to repeal an auto-enrollment and revert to a previous plan if it is better for their needs.

Special Enrollment Periods (SEPs)

The NHC thanks CMS for creating new SEPs to help people who are transitioning off of Medicaid and CHIP into marketplace plans. The continuous eligibility requirements in Medicaid that were in place during the COVID emergency are currently slated to end in April. The [Kaiser Family Foundation estimates](#) that between 5.3 million and 14.2 million people will lose Medicaid coverage during the 12-month unwinding period. We need to make sure that any individuals disenrolled from Medicaid are able to identify and sign up for plans in the marketplaces to better align effective dates with coverage termination of Medicaid or CHIP will help avoid coverage gaps. In addition, lengthening the sign-up window will allow those losing Medicaid or CHIP coverage more time to understand and react to a coverage loss and explore options in the marketplaces. We thank CMS for proactively addressing this potential issue.

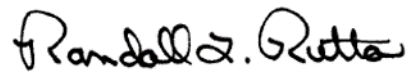
Income Attestation for Premium Eligibility

Streamlining the process to determine if a patient is eligible for subsidies will help make sure that those that are entitled to assistance affording coverage can get it. If no tax data is available for an individual, using the income information attested to in an application will help more people who are eligible access subsidies. The NHC supports this proposal.

Conclusion

Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,

A handwritten signature in black ink that reads "Randall L. Rutta". The signature is written in a cursive, flowing style.

Randall L. Rutta
Chief Executive Officer



New Jersey Primary Care Association

January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

I am writing on behalf of The New Jersey Primary Care Association (NJPCA); our organization represents New Jersey's 23 Federally Qualified Health Centers (FQHCs) and their 129 sites of care. Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. The NJPCA strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

The NJPCA welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees, and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

The NJPCA supports CMS' proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation, meet the ECP participation standard. Stronger oversight and enforcement will ensure that families have adequate access to affordable, quality care provided by health centers within their own communities. The NJPCA recommends that CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, the NJPCA recommends that CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. The NJPCA recommends that CMS enforce this requirement, given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, the NJPCA believes that these good-faith contracts should extend to all FQHCs in their service area.

¹ Section 1311(c)(1)(C)

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

The NJPCA recommends that CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers' continued financial viability. Currently, there is no official tracking mechanism for stakeholders to engage with states and hold them accountable. The NJPCA recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

The NJPCA strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. The NJPCA appreciates the Administration for their continued investment in navigators and enrollment assisters, as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee’s residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH which can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in person. Other health center patients may lack adequate broadband access to apply for insurance online or live in a rural area where it can be challenging to solicit enrollment assistance. The NJPCA appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

The NJPCA also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without spending more money on a monthly premium. On average, healthcare spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person’s take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due to being underinsured.

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person>.

⁶ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1>).

Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

The NJPCA also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably, some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to the continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

The NJPCA appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally Facilitated Marketplace.⁸ Funding for this workforce is important for health centers and their patients. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers with the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations on April 1, an estimated 5 to 14 million people could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

The NJPCA is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services that improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third party creates incentives for private navigators and assisters to direct consumers to certain private products rather than neutrally promoting consumer utilization. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will continue to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need financial support for enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. The NJPCA also strongly advocates for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce the burden on the safety net and generally ensure better public health because having health insurance is associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage, and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

The NJPCA supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers to submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Since brokers and agents are commission-based, unlike Navigators, who are trained to provide unbiased opinions, this could pose a problem for enrollees, especially since these interactions are often web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web brokers and protect enrollees, like health center patients, who choose to use their services.

The NJPCA supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While most Marketplace plans are standardized, this change will help streamline and simplify enrollees' selection process. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, the NJPCA applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and the NJPCA also agrees that four tiers in a plan's drug formulary are sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. The NJPCA appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

The NJPCA also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. The NJPCA appreciates CMS recognizing how administrative functions can impact the continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to a lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently and by utilizing different methods of contact will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

The NJPCA recommends that insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection the NJPCA supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges, and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage, and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide a comment on this proposed rule. If you have any questions about our comments, please contact Ian Allen, Director of Policy and Development, at iallen@njpca.org.

UNITED STATES OF AMERICA
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment
Parameters for 2024**

Agency Docket No. CMS-9899-P, RIN 0938-AU97

**Comments of the Federal LGBTQI Health Policy Roundtable and the LGBTQIA+
Primary Care Alliance**

Pursuant to the Department’s December 21, 2022, notice, 87 Fed. Reg. 244, the Federal LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance submit these comments on the Department of Health and Human Services (hereinafter HHS or the Department) and Centers For Medicare & Medicaid Services (CMS) Notice of Benefit and Payment Parameters for 2024 under the Patient Protection and Affordable Care Act (ACA).

Table of Contents

Interest and Expertise of Commenters	2
Comments	2
Payment HCC for Gender Dysphoria.....	2
Repeal of Prohibitions on Door-to-Door and Other Direct Contacts.....	7
Regarding Providing Correct Information to the FFEs (§ 155.220(j))	10
Regarding Documenting Receipt of Consumer Consent (§ 155.220(j)).....	10
Regarding Failure to File and Reconcile Process (§ 155.305(f)).....	10
Regarding Income Inconsistencies (§§ 155.315 and 155.320)	11
Annual Eligibility Redetermination (§ 155.335).....	12
Special Enrollment Periods (§ 155.420)	12
Plan Display Error Special Enrollment Periods (§ 155.420(d)).....	12
Prohibition of Mid-Plan Coverage Termination for Dependent Children Aging Out	12
Limitations on the Number of Non-Standardized Plans	13
Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235).....	13
Pricing Adjustment for the Hepatitis C Drugs	14
Conclusion	14

Interest and Expertise of Commenters

The Federal LGBTQI Health Policy Roundtable is a coalition of community health centers and national advocacy organizations that share a focus on laws and policies that affect the health well-being of lesbian, gay, bisexual, transgender and nonbinary, queer, and intersex (LGBTQI) populations. Individually and collectively, our organizations work with agencies and offices within the Department – and with other parts of the Administration – to promote legal reforms and federal policies that advance the health and dignity of sexual and gender diverse people. Our community health center members provide primary health care, gender-affirming care, HIV specialty care, and mental health and substance use treatment services to many tens of thousands of individuals and families, many of whom identify as lesbian, gay, bisexual, transgender, queer, or nonbinary. These centers have years of experience helping patients navigate the complexities of the ACA and the health insurance marketplaces and to enroll in Qualified Health Plans (QHPs). Our membership also includes national advocacy organizations representing LGBTQI communities throughout the country.

The LGBTQIA+ Primary Care Alliance includes Federally Qualified Health Centers (FQHCs), State Primary Care Associations, community health centers, and other health care organizations and providers throughout the nation. Alliance members specialize in best practices for providing culturally responsive and compassionate health care and related services for persons identifying as lesbian, gay, bisexual, transgender and gender diverse, queer, intersex, and/or asexual or on the ace spectrum (LGBTQIA+). The Alliance members joining in these comments collectively serve several hundred thousand individuals and families every year, in the Northeast, Mid-Atlantic, Midwest, South, and West. Our members also advocate for federal, state, and local laws and public policies that advance the health and well-being of sexual and gender diverse people, with particular emphasis on persons of color, immigrants, people with disabilities and chronic illnesses, low-income individuals and families, transgender and gender diverse persons, sex workers, drug users, and other particularly marginalized communities.

Comments

Payment HCC for Gender Dysphoria

We appreciate the opportunity to respond to the request for information on a possible payment Hierarchical Condition Category (HCC) for gender dysphoria. Gender dysphoria is a recognized medical condition that can seriously affect the health and well-being of transgender people. While we share the goal of ensuring that people with gender dysphoria can access coverage for the medically necessary health care services they need—which are robustly supported by the scientific literature and more than five decades of medical practice—we do not believe that an HCC for

gender dysphoria is likely to serve that goal under current circumstances in the U.S. health care system. We are also concerned that risk adjustment for gender dysphoria may inappropriately reinforce the perception that transgender identity should inherently be pathologized as a medical condition, rather than as a natural variation in human identity and experience. We therefore do not support further consideration of such an HCC at this time.

In considering the appropriateness of risk adjustment for gender dysphoria, we referred to the ten principles outlined by CMS in the 2014 Notice of Benefit and Payment Parameters Rule. Below we discuss each of the principles that led us to determine that an HCC for gender dysphoria is not warranted at this time.

Principle 1—Diagnostic categories should be clinically meaningful. Gender dysphoria is recognized as a serious medical condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD), as well as by every major U.S. medical professional association. The primary means of coding for gender dysphoria in the U.S. is a series of mental health condition codes (F64.x) in the 10th edition of the ICD (ICD-10). A history of discriminatory insurance exclusions for the treatment of gender dysphoria, however, has long discouraged U.S. clinicians from using these codes, and some clinicians have resorted to using non-specific codes such as E34.9 (endocrine disorder, unspecified) to capture a need for gender-affirming care without flagging the patient as transgender. While there are indications that the F64.x series codes are being used more often as blanket exclusions of coverage for gender-affirming care receded over the past decade, the current political landscape in the U.S. is increasingly hostile to transgender people and their health care needs. As such, it is impossible to determine whether coding practices will reliably move in the direction of more consistent and accurate coding for gender dysphoria, or whether these codes will once again be avoided by many clinicians and patients—potentially in differential patterns based on state laws—for fear of triggering a transgender-specific coverage exclusion or disclosing a patient’s transgender identity to state authorities.

Further, in the continuing absence of patient self-reported data on transgender status in most U.S. health care organizations, some clinicians append codes for gender dysphoria to claims for encounters where care is provided to a transgender person for purposes other than gender affirmation. The misapplication of these codes merely to identify a transgender person rather than to indicate the provision of a service to treat gender dysphoria dilutes the clinical relevance of these codes for risk adjustment purposes.

Finally, the existing codes do not differentiate among appropriate treatment courses for gender dysphoria or incongruence and thus do not specify uniform clinical trajectories that would justify risk adjustment. The expert *Standards of Care for the Health of Transgender and Gender Diverse*

People (Version 8, 2022)¹ emphasizes that the course of care for gender dysphoria is highly individualized and that determinations of medical necessity should be made by providers in close consultation with individual patients: while some people with gender dysphoria may need mental counseling, hormone therapy, and surgeries, others may need only some or none of these services. The course of care for gender dysphoria is also very different not only between individuals but by age: for pre-pubescent children, the only medical intervention that may be indicated is mental health counseling to assist the child and their family in exploring the child's gender through non-medical interventions such as social support. For adolescents, gender affirmation may include mental health support as well as puberty delay medications and eventually exogenous hormone therapy; surgeries are generally not indicated for adolescents and are only performed very rarely and in the presence of severe and debilitating gender dysphoria that is not alleviated by other care alone. For adults, the course of gender-affirming care may include a combination of mental health support, hormone therapy, and surgeries.

In the F64.x code series in the ICD-10, however, while support for children with gender dysphoria is captured in the code F64.2 (gender identity disorder of childhood), care for adolescents versus adults and between patients with differing degrees of clinical severity is not differentiated by the F64.0 (transsexualism), F64.8 (other gender identity disorder), and F64.9 (gender identity disorder, unspecified) codes. The ICD-11 code series maintains this approach with the codes HA60 (gender incongruence of adolescence or adulthood), HA61 (gender incongruence of childhood), and HA6Z (gender incongruence, unspecified). Moreover, the ICD-10 codes currently in use in the U.S. to describe the presence of gender dysphoria or a need for gender-affirming care also include the highly non-specific codes Z87.890 (personal history of sex reassignment) and F64.1 (dual-role transvestism).

For these reasons, we do not believe that coding for gender dysphoria/incongruence as reflected by the DSM-5, ICD-10, or ICD-11 frameworks currently captures discrete clinical trajectories to a degree sufficient to justify risk adjustment under this principle.

Principle 2—Diagnostic categories should predict medical expenditures. Putative claims of higher health care costs are routinely used against transgender people to argue that coverage for gender dysphoria is a burden on the health care system and should be restricted or eliminated. The available evidence shows, however, that removing exclusions of coverage for gender dysphoria from insurance plans is cost-neutral or extremely low-cost. The City and County of San Francisco initially raised premiums when they became the first major U.S. employers to remove blanket exclusions for gender-affirming care in 2001. But after five years, “beneficial cost data led Kaiser and Blue Shield to no longer separately rate and price the transgender benefit—in other words, to

¹ World Professional Association for Transgender Health. (2022). Standards of Care for the Health of Transgender and Gender Diverse People (8th Version). 23 Int'l J. Trans. Health Supp. 1. <https://doi.org/10.1080/26895269.2022.2100644>

treat the benefit the same as other medical procedures such as gallbladder removal or heart surgery.”² A 2013 survey of employers providing coverage for gender-affirming care to their employees found that two-thirds of the employers that provided information on the actual costs of utilization of gender dysphoria treatments reported zero costs, and those employers who reported some costs said that the costs were very low or minimal.³ An analysis of gender-affirming care uptake by transgender people over 6.5 years in one California health plan found a utilization rate of 0.062 per 1,000 covered persons.⁴ Estimates from other states show equally low utilization and related low costs, with North Carolina estimating costs at 0.011% to 0.027% of premiums;⁵ Alaska, 0.03% to 0.05%;⁶ and Wisconsin, “immaterial at 0.1% to 0.2% of the total cost.”⁷ Cost estimates under Wisconsin Medicaid were “actuarially immaterial, as they are equal to approximately 0.008% to 0.03%”⁸ of Wisconsin’s share of its Medicaid budget. Similarly, an analysis in the military context concluded that the financial cost of covering gender-affirming care was “too low to matter”⁹ or, as military leadership noted, “‘budget dust,’ hardly even a rounding error.”¹⁰ This is because only a small percentage of the U.S. population is transgender, and, as noted above, not all transgender people need or use a full scope of services related to the treatment of gender dysphoria.

While we support continuing research to better understand patterns of utilization and expenditures in relation to gender dysphoria, we note that efforts to conduct this research can be susceptible to inherent bias that stems from the fact that, in the absence of self-reported demographic data on transgender status that can be linked to claims data, transgender people can only be identified through encounters with the health care system that result in the generation of claims and related

² City and County of San Francisco Human Rights Commission, *San Francisco City and County Transgender Health Benefit* (Aug. 7, 2007), https://transhealthproject.org/documents/19/SF_transgender_health_benefit.pdf

³ Herman JL, The Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings From a Survey of Employers* (Sept. 2013), <https://escholarship.org/content/qt5z38157s/qt5z38157s.pdf?t=n2ff2l>.

⁴ State of California Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, Reg. File No. REG-2011-00023 (Apr. 13, 2012), at 5, <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>

⁵ Segal Consulting memorandum to Mona Moon, Executive Administrator of the North Carolina State Health Plan, re: Transgender Cost Estimate, Nov. 29, 2016, <https://files.nc.gov/ncshp/documents/board-of-trustees/3a11-3-The-Segal-Company-Transgender-Cost-Estimate-Memorandum.pdf>

⁶ Plaintiffs’ Motion for Partial Summary Judgment, *Fletcher v. Alaska*, No. 1:18-cv-00007-HRH (D. Alaska July 1, 2019), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/fletcher_ak_20190701_plaintiffs-motion-for-partial-summary-judgment.pdf

⁷ *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018).

⁸ *Flack v. Wis. Dept of Health Servs.*, 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).

⁹ Belkin A. Caring for our transgender troops – The negligible cost of transition-related care, 2015 *New Eng J Med* 373:1089-1092, at 1092, <https://www.nejm.org/doi/full/10.1056/NEJMp1509230>.

¹⁰ Declaration of Raymond Edwin Mabus, Jr., Former U.S. Secretary of the Navy, in Support of Plaintiff’s Motion for Preliminary Injunction, *Doe v. Trump*, No. 17-cv-1597-CKK (D.D.C.) filed Aug. 31, 2017, at 41), available at <http://files.eqcf.org/wp-content/uploads/2017/09/13-Ps-App-PI.pdf>

costs. As such, claims data analyses may paint a distorted picture in which transgender people appear to use more health care services and incur higher costs in comparison to people who may have very low or zero utilization and who are presumed to be cisgender due to the absence of codes for gender dysphoria. Any future analyses assessing possible relationships between gender dysphoria and health care costs should rely on self-reported data on transgender status so that transgender and cisgender enrollees can be fairly compared, and they should use long time horizons and incorporate potential cost-savings in long-term mental health and surgical needs that may be realized by timely treatments such as puberty delay medications in adolescence.

Principle 3—Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures. Transgender people are estimated to make up less than 1% of the U.S. population.¹¹ In claims data analyses, the prevalence of people presumed to be transgender based on the presence of codes for gender dysphoria is typically a tiny fraction of a percent.¹² When these already small cohorts are broken down by age to more accurately reflect potential differences in expenditures, the sample sizes for predicting costs become even smaller. Widespread and consistent collection of demographic data on transgender status, as recommended by a 2022 report from the National Academies of Sciences, Engineering, and Medicine,¹³ and linkages of these data with information on health care utilization and expenditures are needed to even begin to build sample sizes that would be sufficient to satisfy this principle.

Principle 10—Discretionary diagnostic categories should be excluded from payment models. As discussed in relation to Principle 1, a great deal of variation currently exists in the degree to which clinicians are aware of the appropriate application of codes for gender dysphoria treatment. Moreover, given elements of the current U.S. political environment that increasingly threaten the safety of transgender people and the providers who care for them, coding practices are unlikely to soon stabilize across age groups, states, and insurance programs. Until transgender people are afforded sufficient protection from discrimination in health coverage and care—and until their health care needs are correctly viewed as legitimate and justified on the basis of the scientific literature that has established the medical necessity of this care—gender dysphoria codes will continue to be treated by providers and patients alike as not only discretionary but potentially dangerous.

¹¹ Herman JL, Flores AR, O’Neill KK. (2022). How Many Adults and Youth Identify as Transgender in the United States. Los Angeles: The Williams Institute. <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>

¹² See, e.g., Jasuja GK, de Groot A, Quinn EK, et al. Beyond Gender Identity Disorder Diagnoses Codes: An Examination of Additional Methods to Identify Transgender Individuals in Administrative Databases. *Med Care* 2020;58(10):903–11.

¹³ National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring Sex, Gender Identity, and Sexual Orientation*. Washington, DC: National Academies Press. <https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation>

Finally, we note that there is no inherent relationship between gender dysphoria/incongruence and any other diagnoses, which the ICD-11 further emphasized by moving gender incongruence from the mental and behavioral health chapter to a separate chapter on “conditions related to sexual health,” where the only other entries are sexual dysfunctions and sexual pain disorders. Given the lack of a meaningful clinical relationship between gender dysphoria/incongruence and other conditions in the ICD-10 and ICD-11, these codes should not be combined with other diagnoses to form a broader HCC that is inclusive of gender dysphoria.

In sum, as long as transgender people continue to be the targets of state-sanctioned mistreatment and exclusion in health coverage and care, the primary means of ensuring access to gender-affirming care must be robust nondiscrimination protections that apply and are enforced nationwide. A strong bulwark of laws and policies protecting transgender people from discrimination in health care and coverage, as well as clear indications that regulators and carriers in states across the country understand and respect the medical necessity of gender-affirming care, are necessary prerequisites for any further consideration of an HCC for gender dysphoria.

Repeal of Prohibitions on Door-to-Door and Other Direct Contacts

We support lifting the prohibition of door-to-door canvassing by Navigators and Assisters. We agree that door to door canvassing should include non-navigator assistance personnel – sending highly trained Assisters/Navigators door to door is not an efficient use of resources but using non-Navigator support personnel help achieve community outreach and education goals and facilitates effective connections to Navigators via “warm hand offs” from educators to Assisters/Navigators. In recognition of their expanded role in assisting patients and clients in accessing social and health care services, these comments also call Navigators and Assisters, “Patient Benefit Insurance Navigators” (PBINs),

We support the view that repealing restrictions on an Exchange's ability to allow Navigators, non-Navigator assistance personnel, and certified application counselors to offer application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact is a positive step that would enable Assisters to reach a broader consumer base in a timely manner—helping to reduce uninsured rates and health disparities by removing underlying barriers to accessing health coverage.

As part of an integrated service model, the PBIN team serves an important role to help ensure access to care by removing or addressing barriers to care from insurance or lack of insurance issues or cost of care issues. Specifically at Whitman-Walker Health (WWH), an FQHC in the DC metropolitan area, the PBIN team helps WWH patients and DC area residents with health insurance eligibility, enrollment, and literacy, connecting people to Medicaid, Medicare, and Qualified Health Plans on the exchange, subsidies, and other insurance options for which they may

be eligible. The PBIN team serve as certified DC Health Link Assistors, providing critical consumer outreach and enrollment assistance to uninsured and under-insured DC residents. Given WWH's patient population and geographic location, the PBIN team also counsels clients from Maryland and Virginia and receives calls from other areas for assistance and advice. The PBIN team works across three sites and manages an Insurance Helpline (where callers get immediately connected to a navigator for assistance). These avenues ensure that the navigators connect promptly and efficiently so that they can screen all patients and area consumers for eligible insurance coverage, assist them in applying for benefits as applicable, and handle and resolve any eligibility or coverage issues.

Evidence shows that millions of people find the process of applying for and using health insurance overwhelming. Many lack basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including Black, Indigenous, and other communities of color. Questions and problems accessing care are not limited to the eligibility and enrollment issues. And with many people seeking assistance qualifying for Medicaid or subsidies, issues are not limited to open enrollment periods.

Insurance navigation services are year-round services by trained experts who can help consumers break down barriers and promote access and health insurance literacy. Given this, it is vital that funding and the scope of services of Navigators include eligibility and enrollment, counseling and all the post-enrollment and access activities highlighted. We support expanded funding for Navigator services. HHS recognizes that PBINs are trained experts on complex systems and supporting the professional development of expert navigators through year-long employment improves efficiency and supports innovation. Additionally, professional navigation should be available year-round to support continuous enrollment, special enrollment periods (SEP), and the full life cycle of consumers years as qualifying events occur. Funding only for open enrollment often results in temporary, seasonal jobs. Temporary employment misses the life cycle of qualifying events and fails to take advantage of the expanded access to SEPs proposed within the notice.

The Biden Administration has been supportive of market reforms that facilitate patient access to health insurance marketplaces, but navigator services are still not emphasized in a way that reflects their essential importance to consumer access. PBINs are service delivery and workforce specialists who unlock access to much needed health care services. As described briefly above, they operate year-round on the front-line of our operations, conducting more than just eligibility and enrollment screenings. PBINs also screen clients and patients for other needs, including health-harming legal issues that affect social determinants of health, like housing, employment, and education, and health related social needs like food security, transportation, and income. Given our focus on the LGBTQ community, PBINs also screen for alignment with name and gender

marker on identity documents to ensure being asked for your insurance card and identification at a health visit isn't creating a barrier for people.

Expert navigators are trained to screen for social determinants of health and legal issues in the natural course of conversation when enrolling patients and clients, and to identify upstream issues to improve health. WWH navigation services are available in Spanish, English, and Amharic and are an essential part of a culturally competent practice. Screening for these additional barriers is organic, as the PBINs have much of this information from their screening for health insurance options - income, family size, immigration status, name, gender marker, employment status, housing status. By using that information to identify potential other needs, the PBINs serve as a "upstream screener" and connector to other services like legal services who can assist to break down other systemic barriers critical to increased patient engagement, empowerment of consumers, and improving overall health care delivery. Conducting insurance navigation helps build health insurance literacy for our diverse patient population, helps give providers more care options when patients are insured, and helps our health center have stronger financial stability and long-term sustainability.

WWH is an FQHC with one of the oldest navigation programs in the nation. It is their experience that no matter someone's education, age, or computer literacy, people need navigation services. Despite the reforms that we have seen increasing enrollment periods, expanding tax credits for enrollees, protections from renewals and terminations of Medicaid during the COVID-19 public health emergency (PHE), and expansions of insurance coverage, consumer needs for Navigation services remain high and we are as busy as ever helping people navigate the very complicated health care system.

We support the proposal that changes rules to allow sharing information with Navigators of consumers who have been determined ineligible for Medicaid. The NPRM makes clear that consumers may only be approached when ineligible for Medicaid. Unfortunately, this regulation misses the opportunity to leverage PBIN expertise to support re-enrollment. Navigators need to be able to talk eligibility across options and engage by helping consumers to recertify Medicaid or discuss life events – new job/higher income, family size shift, etc – that may change eligibility. Sharing of information should be seen as part of supporting a “no wrong door” policy and a coordinated, robust screening process.

We support the change to allow Assisters and Navigators to offer application assistance door-to-door and through other unsolicited means at this stage of the implementation of the ACA. We agree that now that the Exchanges and their Assister programs have been in operation for almost 10 years, Assisters have more name recognition and consumer trust within the communities the Assisters serve. Accordingly, HHS believes that its previous concerns related to consumers' privacy and security interests and consumers not knowing what to expect when interacting with

Assisters have been sufficiently mitigated with the measures HHS has enacted such that a blanket prohibition on unsolicited direct contact of consumers by Assisters for application or enrollment assistance is no longer necessary.

Regarding Providing Correct Information to the FFEs (§ 155.220(j))

We support a statutory requirement to

“...explicitly require agents, brokers, or web-brokers assisting consumers with completing eligibility applications through the FFEs and SBE-FPs to confirm with those consumers the accuracy of the information entered on their applications prior to application submission or document the consumer has reviewed and confirmed the information to be accurate.”

This regulation reasonably incentivizes the agent to take due care when engaging with clients and establishes a duty to confirm the information with the consumer. The rule seems likely to improve the accuracy of the information received in applications by establishing a second level of review and is constructed to support consumer-driven and informed consent of consumers as well.

The requirements on the documentation of consent seem carefully calibrated to balance the need for ease of understanding, storage of the information, and creating incentives for agents and brokers to explore and innovate new best practices for their business and the consumers they serve. The minimum standard of keeping records for 10 years helps establish consumer expectations and uniformity across brokers and agents.

Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))

We are concerned about the security of consumer consent records and want to ensure strong data security and data hygiene standards are applied to any potentially sensitive information, including private health data. For example, is the consumer consent documentation kept, but not the underlying consumer application data? What happens to the consent confirmation? Is it encrypted, or otherwise kept physically and digitally secure? How long do brokers retain consumer application data? Under what conditions is this data kept? Large troves of consumer data retained by agencies and brokers represent a substantial risk to consumer privacy, which can be minimized by leveraging emergent best and promising practices on data retention and storage.

Regarding Failure to File and Reconcile Process (§ 155.305(f))

We agree that the costs of the current policy that ends a consumer's coverage are outweighed by the benefits of encouraging robust enrollment and participation in insurance programs. The proposed rule to not terminate because someone failed to file taxes for two years is an excellent

addition. As noted, the IRS records may be inaccurate, and it is important that consumers not be improperly removed from a plan due to error on the part of the government.

Additionally, this change supports consumers who may not properly understand the consequences of failing to file, due perhaps historical expectations that lack of income negates the necessity to file taxes. In our practice, many consumers do not fully understand – even with coaching – the relationship between taxes and health insurance. The connection in many minds is non-obvious, complicated, and questionable. Finally, many people file late, some files years late after realizing they need to. This new language is a good relaxation of the original requirement to enhance consumer protections in support of continuity of coverage, and reduce the resources allocated to needless appeals. The proposed rule extending the grace periods instituted during the COVID-19 PHE will give consumers ample time to adjust to new requirements while Navigators and Assistants implement HHS’s new flexibilities to engage in consumer education and the new requirements that support accurate reporting of consumer data, ensuring the efficient administration of HHS resources.

Rather than provide an extra year of flexibility, we suggest that it may further support HHS’s objectives to remove the penalty entirely. This would ensure that eligible consumers retain coverage under all circumstances. HHS should consider the impact of eliminating the penalty on the market and if HHS has a less restrictive means of administering the filing requirement. For example, consumers found to be ineligible for APTC could be charged premiums retroactively.

Regarding Income Inconsistencies (§§ 155.315 and 155.320)

We support the proposed regulation allowing self-attestation of projected income and family size in the absence of data from the IRS or when such data from the IRS fails to reflect a change of circumstance that is relevant to a consumer's eligibility for insurance affordability programs. Self-attestation and alternative documentation procedures support, to the greatest extent practicable, the inclusion of potentially eligible consumers in the insurance programs. This is an excellent use of Department resources as a high value is placed on consumer participation in insurance plans and incentivizes the IRS to provide timely information to the Exchange. The added flexibility supports an approach that meets consumers needs and balances the Department’s interest in the judicious use of federal funds.

We support the range of additional flexibilities, especially the mandatory extension for consumers to provide documentation supporting their eligibility for advanced premium tax credits (APTCs) and cost sharing reductions (CSRs). Many patients who benefit most from these programs are working in households with multiple sources of income woven together to support a family. These beneficiaries are well-poised to benefit from these changes, and potentially deeply harmed when

incorrectly removed from coverage. The additional flexibilities support consumers with the needed time to understand the requested information and gather it from across their household.

Annual Eligibility Redetermination (§ 155.335)

We support the proposed rule directing re-enrollment into lower or same cost, high generosity plans. This proposal is well calibrated to protect consumers who are most likely to need additional support and could benefit from the updated guided auto enrollment rules. As HHS notes, the proposed change will have a protective effect on consumers, likely lowering out of pocket costs while directing consumers to high-value products on the exchanges when they do not actively re-enroll themselves.

Special Enrollment Periods (§ 155.420)

We support the proposed change to requirements to allow a household to enter a special enrollment period based on a single member of that household having a qualifying event. This change supports inclusion of households with different family structures and access to affordable insurance options for more consumers, especially those who move from Medicaid plans to marketplace plans. This will be particularly important for consumers facing the end of Medicaid enrollment flexibilities upon the expiration of the COVID-19 PHE, which is expected starting April 1, 2023. The proposed change more accurately reflects the lived experiences of consumers, in which often the changed circumstances of a single person within a household are part of a larger ecosystem of resources, income, and insurance products. For example, a qualifying event, like a birth, marriage, or job loss, may require a household to make changes to make certain other changes, and this expansion of SEP supports the lived experiences of many families.

Plan Display Error Special Enrollment Periods (§ 155.420(d))

We support the proposed changes to ensure that errors in Marketplace plan displays do not adversely affect consumers. We believe this change encourages the efficient operations of Marketplaces and the Exchanges while reducing the burden on consumers to prove an error occurred.

Prohibition of Mid-Plan Coverage Termination for Dependent Children Aging Out

We support the proposed prohibition on terminating coverage mid-year for dependent beneficiaries of plans who age out. This proposed change supports the industry standard of enrolling in health plans during the open enrollment periods at the end of each calendar year and creates stability for parents and families during transitions.

We see the coverage gap scenarios that HHS highlights in their NPRM. During the COVID-19 PHE-related SEP, Washington, DC's Marketplace exchange allowed consumers to essentially choose the effective date – not mid-month but retroactive, current, or prospective enrollment. Recognizing that mid-month enrollment is logistically difficult for insurers, an approach that allows for flexibility as to the effective date to meet the needs of consumers is balanced with the need for insurers to efficiently administer their plans.

Limitations on the Number of Non-Standardized Plans

We support the proposed rule to limit the number of non-standardized plans as reasonably designed to produce efficient health exchanges that are understandable and navigable by consumers. This proposed regulation may have a beneficial effect of reducing incentives for insurers to drive consumers from high value products through confusing marketing techniques. Combined with marketplace requirements based on meaningful differences, the proposed change reduces incentives to market a plethora of relatively cheap plans and supports innovation by insurers.

Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

We support the proposed changes to network adequacy and Essential Community Provider (ECP) standards. ECP requirements are a key feature of HHS regulations that ensure vulnerable communities, including low-income communities, LGBTQIA+ people, and communities of color are able to access health care services that are affordable and culturally and linguistically appropriate. Many LGBTQ+ serving health care centers are ECPs, and we support robust requirements that specialized ECPs with specific expertise be included in network adequacy requirements, including the proposed rule to create new standalone classes for ECPs for Substance Use Disorder (SUD) Treatment and Mental Health Facilities. We note that for patient access purposes, it is important that Mental Health Facilities and SUD Treatment centers used to satisfy the proposed requirements include facilities that are secular in nature, as many LGBTQIA+ people and racial and ethnic minority patients report discomfort with religiously affiliated programs.

We support the proposed changes to expand QHP requirements for contracting with Family Planning and FQHC ECPs to a 35% threshold. This ensures that network adequacy requirements result in meaningful coverage for underserved populations.

In the experience of WWH in Washington DC, low-income clients from Virginia and Maryland with exchange plans may find that WWH is excluded from their network because the plan issuer identifies the in-state ECPs, but not those in DC. HHS can provide clarification that a plan's service area and geographic distribution requirements include nearby metropolitan areas. Additionally, we propose a clarification that the threshold requirements do not prohibit adding to the plan's network, just removing providers from a plan's network.

In response to questions about ensuring network adequacy of certified QHPs, we recommend that HHS look to the requirements for Essential Health Benefits (EHBs) sold on state exchanges. The 10 categories of EHBs provide consumers with confidence to understand the quality of the insurance plans they are purchasing and provide market stability for insurers. Consumers would also benefit from plans having up-to-date information on available providers on insurers online network platforms. It may be helpful for consumers to understand whether an ECP is included or covered if the meaningful differences between network robustness is indicated by metal level.

Pricing Adjustment for the Hepatitis C Drugs

The Department's proposed rule to continue a market pricing adjustment specific to Hepatitis C drugs in models for the 2024 benefit year seems reasonably well calibrated to reduce the incentives that issuers will create discriminatory plans to drive away people living with or at risk for Hepatitis C. Virus (HCV). HCV cure therapies represent a breakthrough in HCV treatments as the NPRM notes, the costs are changing rapidly among drug products. A pricing adjustment for HCV drugs encourages formularies with sufficient access to all effective treatments for patients that need them.

Conclusion

The LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance are pleased to participate in this important discussion. We would be happy to provide additional information or to assist CMS or the Department in any other way. For more information regarding any portion of these comments, please contact Benjamin Brooks, Associate Director of Policy and Education at Whitman-Walker Institute via bbrooks@whitman-walker.org.

January 30, 2023

Ellen Montz, Director & Deputy Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically via: www.regulations.gov

RE: CMS–9899–P, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters (NBPP) for 2024

Dear Dr. Montz:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments in response to the proposed rule updating the Notice of Benefit and Payment Parameters for 2024.

ACAP is an association of 78 not-for-profit and community-based Safety Net Health Plans (SNHPs). Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals, including over 850,000 Marketplace enrollees. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. 25 of ACAP’s Safety Net Health Plan members and Partner Plans offer qualified health plans (QHPs) in the Marketplaces for 2023.

ACAP has chosen to respond to a subset of proposals in the update of the Notice of Benefit and Payment Parameters for 2024 that are particularly relevant to Safety Net Health Plans (SNHPs). ACAP appreciates the Administration’s desire to strengthen the integrity of the Marketplaces; our comments are ensuring market stability for SNHPs and the consumers they serve. ACAP member plan enrollees are generally low-income populations and we would like to emphasize that the comments herein support SNHPs in their efforts to serve their communities.

Our comments are summarized in brief below.

Summary of ACAP Comments

Risk Adjustment Issuer Data Requirements: *ACAP supports CMS’ proposal to collect data on HRA utilization and enrollment through a new QSEHERA indicator; however, we urge CMS to not factor HRA enrollment into risk adjustment at present or in any way penalize issuers for not submitting HRA data. Issuers generally have very limited information as to whether their enrollees are enrolling with an HRA.*

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards: *ACAP supports CMS’ proposal to eliminate requirements that prevent*

navigators and assisters from going door-to-door or otherwise provide direct outreach to consumers.

Requiring Agents and Brokers Provide Correct Information and Documenting Receipt of Consumer Consent: *ACAP supports CMS' proposal to require agents, brokers, and web-brokers document that eligibility information has been reviewed and confirmed as accurate by the consumer or authorized representative and retain such documentation for ten years. We urge CMS to go further and require agents, brokers, and web-brokers also inform consumers if they are CSR eligible and gain their consent if they are not enrolling them in CSR-eligible QHPs.*

Failure to File and Reconcile Process: *ACAP supports CMS' proposal to continue the FTR pause and develop a two-year FTR process, keeping APTC-eligible consumers enrolled in coverage.*

Annual Eligibility Redetermination: *ACAP supports CMS' proposal to modify re-enrollment hierarchies such that enrollees who are eligible for CSRs and who would otherwise be automatically re-enrolled in a bronze level QHP without CSRs instead be automatically re-enrolled in a silver-level QHP with income-based CSRs in the same product with a lower or equivalent net premium after APTC. ACAP also supports CMS' proposal to modify re-enrollment hierarchies such that if an enrollee's QHP is no longer available, they would be re-enrolled into plans with the most similar network, within the same product and metal level. ACAP wishes to register concern with changing a consumer's QHP based solely on premiums and strongly objects to CMS' proposal to consider auto-enrolling consumers who have chosen the lowest-cost silver plan one year into the lowest-cost silver plan the following year. Finally, while ACAP is supportive of auto-enrollment as a concept, we urge CMS to put additional thought into how to operationalize such a process, as we believe CMS' proposed policy would pose multiple operational challenges and is rife for abuse. Without additional guardrails, ACAP could not support CMS' current proposal to auto-enroll delinquent consumers into new products mid-year.*

Special Enrollment Periods: *ACAP supports CMS' proposal to clarify that only one person in a household needs to be eligible for a Special Enrollment Period (SEP) in order for the entire household to qualify for a SEP. ACAP urges CMS to consider finalizing a narrower proposal of permitting an earlier effective date only to consumers who attest to a future loss of Medicaid or CHIP coverage. ACAP urges CMS to consider additional guidance to ensure proper coordination of benefits during any overlapping coverage. ACAP supports CMS' proposal to extend the SEP for consumers losing Medicaid or CHIP coverage from 60 days to 90 days.*

FFE and SBE-FP User Fee Rates: *ACAP supports CMS' proposal to reduce the FFE user fee rate to 2.5 percent of total monthly premiums and the SBE-FP user fee rate to 2 percent of monthly premiums.*

Non-Standardized Plan Option Limits: *While ACAP very much agrees that plan choice overload in the Exchanges is a problem that needs to be addressed, we object to CMS' proposed*

limitations on non-standardized plan options; we do not agree with CMS' assessment that limiting issuers non-standardized plan options as proposed will ensure a sufficiently diverse range of plan offerings that are innovative or meet a variety of consumers unique health needs. ACAP urges CMS to consider additional options, including improved plan choice architecture, changing the requirement from provider network type to network ID, allowing additional non-standardized plan options with supplemental benefits, or a re-thought-out meaningful difference standard. ACAP believes that a strong meaningful difference standard is overarchingly a better approach than simply limiting non-standardized options as proposed, however, we do not believe that CMS' proposal of using a \$1,000 difference in deductible as the standard for meaningful different plans hits the mark either and urge CMS to consider additional options, which are detailed herein. Finally, ACAP urges a phased-in approach regardless of which proposal to limit QHPs that CMS decides to move forward with.

Plan and Plan Variation Marketing Name Requirements for QHPs: *ACAP believes that issuers should have the ability to name plans in a manner that allows the issuer to highlight unique components of their offerings. However, ACAP supports CMS' proposal to verify that plan names are accurate and not misleading to consumers.*

Plans That Do Not Use a Provider Network: Network Adequacy and Essential Community Providers: *ACAP fully supports CMS' proposal to remove the exception stating that a plan that doesn't use a provider network is not required to comply with network adequacy standards. We believe that a plan without a provider network is not in the interest of consumers shopping for QHPs and can put them at risk for high out-of-pocket costs.*

Compliance With Appointment Wait Time Standards: *ACAP urges CMS to delay implementation of the new appointment wait time standards by at least one year.*

Essential Community Providers: *ACAP supports CMS' proposal to add Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers as categories to the Essential Community Provider (ECP) requirements. We also support CMS' proposal to require that issuers meet an overall 35 percent ECP threshold as well as a separate 35 percent threshold for federally qualified health centers (FQHCs) and Family Planning Providers so long as CMS retains its current justifications process for issuers who are unable to meet the standard.*

Termination of Coverage or Enrollment for Qualified Individuals: *ACAP recommends that CMS institute a minimum requirement that issuers include notice of delinquency on their monthly invoices as soon as the first missed payment and allow issuers to continue to send additional notices using additional methods.*

Expanded Comments

ACAP's comments are expanded below, with additional background.

Risk Adjustment Issuer Data Requirements

Due to the varied impact of risk adjustment transfers on our member plans, ACAP is largely refraining from comments on the risk adjustment program. We do, however, wish to comment on one proposal.

Collection and Extraction of the QSEHRA Indicator

CMS proposes to collect an extract through issuers EDGE Server filings a new Qualified Small Employer Health Reimbursement Arrangement (QSEHERA) indicator, as it already does with an Individual Coverage Health Reimbursement Arrangement (ICHRA) indicator, in order to allow CMS to examine whether there are any unique actuarial characteristics of the HRA population. ACAP believes it is important to monitor HRA utilization and enrollment to ensure that employers are not offering HRAs only to certain classes of employees, thereby sending higher risk enrollees to the Exchanges, for example.¹ Accordingly, we continue to support efforts by CMS to identify any unique characteristics of the HRA population and consider whether there may be any impact on the risk adjustment program. We support CMS' efforts to collect this data through an EDGE indicator, however, we wish to note that our member plans generally have no information as to whether their enrollees are enrolling with an HRA. ACAP member plans are happy to provide this information—when available—through EDGE, however, any information they do have is extremely limited, so we urge CMS to consider other ways of attaining this data. We also urge CMS not to factor HRA enrollment into risk adjustment at present or in any way penalize issuers for not submitting HRA data through EDGE, as they are rarely aware if their enrollees have an HRA and collecting such data is haphazard and incomplete at best. CMS proposes a transitional approach that will ultimately require issuers to make a good faith effort to collect and submit both ICHRA and QSEHRA data; we urge CMS to instead leave these data submission fields as voluntary and without risk of penalty.

ACAP supports CMS' proposal to collect data on HRA utilization and enrollment through a new QSEHERA indicator; however, we urge CMS to not factor HRA enrollment into risk adjustment at present or in any way penalize issuers for not submitting HRA data. Issuers generally have very limited information as to whether their enrollees are enrolling with an HRA.

Risk Adjustment Data Validation Requirements

Discontinue Lifelong Permanent Conditions List and Use of Non-EDGE Claims in HHS–RADV

CMS proposes to discontinue the use of the Lifelong Permanent Conditions (LLPC) list and the use of non-EDGE claims starting with the 2022 benefit year of HHS–RADV. ACAP opposes CMS' proposal and wishes to note that members with lifelong permanent conditions still need—and utilize—care, regardless of whether their provider has included that diagnosis or there is a corresponding EDGE claim. If the intent of risk adjustment is to level the playing field so that carriers are appropriately compensated for high-risk patients, permitting the capture of data based on lifelong permanent conditions is one way to do so.

¹ See ACAP's previous comments and Wakely Consulting Group impact analysis of the 2018 proposed rule on Health Reimbursement Arrangements and Other Account-Based Group Health Plans at <https://www.communityplans.net/policy/comments-on-proposed-health-reimbursement-arrangement-regulations/>

ACAP opposes CMS' proposal to discontinue the use of lifelong permanent conditions as part of risk adjustment data validation processes.

**Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor
Program Standards**

CMS proposes to repeal provisions that prohibit Navigators and other personnel from going door-to-door or using other unsolicited means of direct contact to provide enrollment assistance to consumers. ACAP supports this proposal and agrees with HHS' efforts to eliminate barriers to coverage access by maximizing pathways to enrollment. ACAP agrees with CMS' assessment that after ten years there are adequate safeguards in place to protect consumer information and supports CMS' efforts to reach a broad consumer base in a variety of ways in order to reduce uninsurance rates. As CMS notes, this may be particularly important for consumers whose ability to travel is limited due to disability, are immunocompromised, or lack transportation—exactly the consumers that ACAP plans strive to support.

ACAP supports CMS' proposal to eliminate requirements that prevent navigators and assisters from going door-to-door or otherwise provide direct outreach to consumers.

**Requiring Agents and Brokers Provide Correct Information and Documenting Receipt of
Consumer Consent**

CMS proposes to require agents, broker, or web-brokers assisting with or facilitating enrollment through the Federally-Facilitated Exchanges (FFE) and State Based Exchanges using the Federal Platform (SBE-FPs) or assisting an individual with applying for Advance Premium Tax Credits (APTCs) or Cost-Sharing Reductions (CSRs) for QHPs to document that eligibility application info has been reviewed by and confirmed to reviewed by the consumer or authorized representative prior to application submission. CMS also proposes that the documentation of such must be maintained by the agent or broker for a minimum of 10 years. Finally, CMS proposes the agents, brokers, and web-brokers document receipt of consumer consent. ACAP supports CMS proposals as part of the minimum standards for agents, brokers, and web-brokers. ACAP's member plans not infrequently learn of consumer complaints regarding accuracy of information, which can be of particular concern if a consumer receives an incorrect APTC determination, impacting their tax liability, or even are unknowingly enrolled in a QHP at all. Accordingly, we support CMS' proposals.

We also urge CMS to similarly require that agents and brokers inform consumers if they are CSR eligible and receive consumer attestation or confirmation to this effect. ACAP member plans are aware of instances in which agents and brokers are enrolling CSR-eligible consumers into bronze plans instead of silver CSR options because the brokers themselves preference the bronze plan—such as, for example, due to a higher commission. We urge CMS to consider require agents, brokers, and web-brokers 1) inform consumers if they are CSR eligible and what it means to be

CSR eligible, 2) inform consumers if they are leaving CSR subsidies on the table, and 3) document consumer acknowledgement and consent accordingly.

ACAP supports CMS' proposal to require agents, brokers, and web-brokers document that eligibility information has been reviewed and confirmed as accurate by the consumer or authorized representative and retain such documentation for ten years. We urge CMS to go further and require agents, brokers, and web-brokers also inform consumers if they are CSR eligible and gain their consent if they are not enrolling them in CSR-eligible QHPs.

Failure to File and Reconcile Process

CMS is proposing to amend requirements that prohibit an Exchange from determining a taxpayer eligible for APTC if they have failed to file a federal income tax return and reconcile their past APTC for one year, changing the requirement to two years. By requiring Exchanges to determine an enrollee ineligible for APTC only after two years of failure to reconcile (FTR) status instead of one, it gives Exchanges opportunities to do outreach to enrollees at risk of losing APTC and to provide APTC access for an additional year. Under proposed changes, Exchanges on federal platform would continue to send notices to consumers throughout the first year of FTR status as an education opportunity for consumers needing to file and reconcile or who will be risk losing APTC the following year. As CMS notes, this change will reduce the number of consumers going through the appeals process for reinstatement of their APTC due to an initial denial due to FTR status, but more importantly, help keep consumers enrolled in coverage because, as CMS notes, consumers who lose APTCs tend to drop coverage completely. APTC-eligible consumers are a significant portion of the Marketplace and are also the population that ACAP's member safety-net health plans seek to serve—including through continuity of coverage. As CMS notes, the new two-year FTR policy will help consumers avoid gaps in coverage by increasing retention; it will also help protect consumers from accruing large tax liabilities over multiple years by notifying and ending APTC eligibility for consumers with a two-year FTR status.

ACAP supports CMS' proposal to continue the FTR pause and develop a two-year FTR process, keeping APTC-eligible consumers enrolled in coverage.

Annual Eligibility Redetermination

CMS proposes to modify re-enrollment hierarchies such that enrollees who are eligible for CSRs and who would otherwise be automatically re-enrolled in a bronze level QHP without CSRs, would instead be automatically re-enrolled in a silver-level QHP with income-based CSRs in the same product with a lower or equivalent net premium after APTCs. ACAP supports this proposed change and agrees with CMS' assertion that it will provide greater financial security to bronze plan enrollees who don't actively re-enroll and may not be aware that a more generous silver plan is available for the same or lower cost. This may be particularly beneficial for

consumers who last chose their plan before the enhanced APTCs became available and were not eligible for income-based CSRs when they first enrolled.

CMS also proposes to modify the re-enrollment hierarchy to ensure enrollees whose QHPs are no longer available to them would be re-enrolled into plans with the most similar network to the plan they had the previous year, within the same product, with an opportunity for issuers to provide justification if they believe a product with a different network ID actually has a more similar network to the discontinued QHP. ACAP supports this proposal so long as the consumer is not moved to a different product, thereby overriding their enrollment choices.

Finally, CMS seeks feedback on additional changes for future years. First, CMS asks if it should consider modifying the re-enrollment process to incorporate other factors, including net premium and total out-of-pocket cost. We are concerned about changing a consumer's QHP based primarily on premium, as the consumer may well have chosen a particular product because of its network or other feature, including benefits or cost-sharing, and we believe changing a consumer's QHP simply based on premium or predicted cost-sharing could set the consumer up for unexpected surprises during the year when they go to utilize their coverage.

Additionally, while premium is an important factor to consider, we urge CMS to consider the role of CSRs before moving the consumer to a higher metal-tier product, even if the net premiums are lower. Specifically, we are concerned that since some gold plans have lower premiums than their silver counterparts due to "silver-loading, the projected out-of-pocket costs for the gold plan may appear lower, however, because of cost-sharing reductions, may not actually be so depending on that consumer's utilization patterns. If a consumer is CSR-eligible, we would be hesitant to recommend automatically moving them into a gold plan—even if premiums are lower—without a thorough evaluation by CMS to confirm whether the total out-of-pocket would remain lower across the board. We urge CMS to conduct such an evaluation and present the results in future notice-and-comment rulemaking before incorporating such a change into the reenrollment hierarchy.

CMS also seeks comment on whether, if a consumer has chosen the lowest-cost silver plan, whether in future years CMS should auto-enroll them into the lowest-cost silver plan the following year. We object strongly to this proposal. First, we would have grave concern if CMS were to move consumers into QHPs offered by other issuers or that are different product-types, or even simply a different QHP—even of the same product type and from the same issuer—based solely on cost; doing so would effectively negate any role of consumer choice and would, in fact, override the consumer's choice even if their current plan is still available. Further, there are cases in which the consumer may have numerous \$0 QHP options available to them and have picked the one that best suits their needs, regardless of whether it may be technically the lowest-cost QHP available. CMS could, instead, work with the Exchanges to send consumers a plan grid showing them their available alternatives, including those that might be of lower-cost, but we would strongly object to changing the consumer's QHP simply based on price, and especially if their current QHP is still available.

Lastly, CMS seeks comment on potential auto-enrollment policies for future years. Specifically, CMS asks about a policy in which consumers who have entered delinquency on their QHP premiums would be auto-enrolled into QHPs with no net premium after application of APTCs. We believe this should be an option at the issuer's discretion, but we wish to raise a number of concerns and parameters that we believe CMS needs to more thoroughly evaluate. While we agree that even small net premiums can decrease enrollment, and that enrollees may experience life changes that make it challenging to pay their premiums on a monthly basis, CMS' policy as proposed would pose multiple operational challenges and is rife for abuse. First, CMS needs to consider how this would affect the Batch Auto Re-enrollment (BAR) file process. Secondly, we urge CMS against any retroactive auto re-enrollment into another QHP, as it would pose significant challenges from a coordination of benefits standpoint if consumers used any services and plans received APTCs during their grace period. Thirdly, we advise CMS that auto-enrolling delinquent consumers into another QHP could lead to significant abuse. Specifically, many consumers already engage in "premium holidays," in which they stop paying for coverage during the final three months of a given year, knowing they can start fresh after open enrollment or even pay back premiums during their grace period if it ends up that they need services. Similarly, with this proposal consumers could easily pick a more robust plan with a higher premium, use it to receive more robust coverage, and then stop paying knowing they will be dropped down to a plan with, for example, a higher deductible or cost sharing or different benefits. Perhaps CMS could consider placing guardrails on such a proposal timed with the last three months of the coverage year, when consumers are most likely to drop coverage, or for those who ultimately choose not to make a binder payment. Finally, we urge CMS to consider whether this might involve moving consumers down a metal tier, such as from silver to bronze, and how that might contradict CMS' other efforts within this notice.

All of this being said, ACAP does, however, support the concept of auto-enrollment, particularly in the context of consumers who are losing Medicaid or CHIP coverage, for example, and we urge CMS to consider ways to operationalize such a process. We also urge CMS to put more thought and specificity into an auto-enrollment process for consumers who may be eligible for \$0 plans and propose it in future notice and comment rulemaking. We wish to also note that there are other ways to reduce such gaps in coverage for consumers who become delinquent. For example, CMS could permit issuers to, along with payment delinquency notices, display a grid of other options to the consumer and permit a mid-year change at the issuer's discretion.

ACAP supports CMS' proposal to modify re-enrollment hierarchies such that enrollees who are eligible for CSRs and who would otherwise be automatically re-enrolled in a bronze level QHP without CSRs instead be automatically re-enrolled in a silver-level QHP with income-based CSRs in the same product with a lower or equivalent net premium after APTC. ACAP also supports CMS' proposal to modify re-enrollment hierarchies such that if an enrollee's QHP is no longer available, they would be re-enrolled into plans with the most similar network, within the same product and metal level. ACAP wishes to register concern with changing a consumer's QHP based solely on premiums and strongly objects to CMS' proposal to consider auto-enrolling consumers who have chosen the lowest-cost silver plan one year into the lowest-cost

silver plan the following year. Finally, while ACAP is supportive of auto-enrollment as a concept, we urge CMS to put additional thought into how to operationalize such a process, as we believe CMS' proposed policy would pose multiple operational challenges and is rife for abuse. Without additional guardrails, ACAP could not support CMS' current proposal to auto-enroll delinquent consumers into new products mid-year.

Special Enrollment Periods

Use of Special Enrollment Periods by Enrollees

CMS proposes two technical corrections to clarify that only one person in a household applying for coverage needs to be eligible for a special enrollment period (SEP) in order for the entire household to qualify for a SEP. ACAP supports the proposed technical correction.

ACAP supports CMS' proposal to clarify that only one person in a household needs to be eligible for a Special Enrollment Period (SEP) in order for the entire household to qualify for a SEP.

Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage

CMS also proposes to permit earlier coverage effective start dates for consumers attesting to a future loss of MEC. As CMS notes, in some states, Medicaid and CHIP coverage is regularly terminated mid-month, which leads to a gap in coverage for consumers whose coverage is being terminated. We support CMS' efforts to eliminate gaps in coverage, particularly as millions of consumers are expected to lose their Medicaid coverage during the unwinding of the public health emergency continuous coverage requirements. However, coordination of benefits across two issuers during the overlapping time period can be extraordinarily difficult, and in many cases the QHP issuer may not know the enrollee has another form of coverage at the same time or who is the primary versus secondary payer.

Accordingly, unless CMS can work with the IRS to permit APTC's for mid-month coverage effective dates in additional notice and comment rulemaking, which would be preferable, we urge CMS to finalize a narrower version of this proposal: only permitting an earlier effective date for consumers who will be losing Medicaid or CHIP coverage, as issuers already have some experience in working with Medicaid in similar scenarios. However, rules around primary versus secondary payers are less clear with other forms of coverage, such as employer coverage. Regardless, we urge CMS to consider additional guidance as part of the Final Notice of Benefit and Payment Parameters to ensure proper coordination of benefits during the overlap. We also wish to note that we agree with CMS' decision not to propose retroactive coverage effective dates for consumers reporting past loss of MEC, due to significant operational burden.

ACAP urges CMS to consider finalizing a narrower proposal of permitting an earlier effective date only to consumers who attest to a future loss of Medicaid or CHIP coverage. ACAP urges CMS to consider additional guidance to ensure proper coordination of benefits during any overlapping coverage.

Special Rule for Loss of Medicaid or CHIP Coverage

CMS proposes to provide more time for consumers who lose Medicaid or CHIP to report loss of such coverage and enroll in Exchange coverage, aligning the special enrollment period window following loss of Medicaid or CHIP with the 90-day reconsideration period, instead of the current 60-day limit. Especially given the significant consumer confusion and reconsideration requests expected as part of the continuous coverage unwinding, we support extending the SEP for consumers losing Medicaid or CHIP coverage from 60 days to 90 days.

ACAP supports CMS' proposal to extend the SEP for consumers losing Medicaid or CHIP coverage from 60 days to 90 days.

FFE and SBE-FP User Fee Rates

CMS proposes to reduce the FFE user fee rate to 2.5 percent of total monthly premiums and the SBE-FP user fee rate to 2 percent of monthly premiums. Given CMS' assessment that there will be greater overall enrollment due to the enhanced APTCs, and therefore greater total amount of user fees collected, we support CMS' decision to reduce the user fee rates. Reducing the user fees will enable ACAP's member plans to offer lower premiums than they otherwise could.

ACAP supports CMS' proposal to reduce the FFE user fee rate to 2.5 percent of total monthly premiums and the SBE-FP user fee rate to 2 percent of monthly premiums.

Non-Standardized Plan Option Limits

HHS proposes to limit the number of non-standardized plan options that issuers can offer through the exchange on the federal platform (including SBE-FPs) to two non-standardized plan options per product network type and metal level in any service area for PY2024. Under this proposed requirement, an issuer would, for example, be limited to offering through an Exchange, two gold HMO and two gold PPO non-standardized plan options in any service area in PY 2024 and beyond. ACAP has previously commented that it agrees with CMS' assessment that plan choice overload may lead to poor enrollment decisions by some and complete indecision by others. We fully support limiting plan choice overload for consumers, in particularly the crowding of the market by issuers looking to gain market share by having the lowest or second-lowest silver plan. However, ACAP does not agree with CMS' assessment that limiting issuers non-standardized plan options as proposed will ensure a sufficiently diverse range of plan offerings that are innovative or meet a variety of consumers unique health needs.

Unfortunately, the recent addition of standardized plans has, while providing consumers the ability to compare certain plans, also exacerbated plan choice overload, as many issuers simply added them to their repertoire of options rather than eliminating others. We also know that silver plan offerings tend to dominate, with a plethora of options crowding the lower end of the

premium market. We do, however, believe there are other ways of reducing the number of plans on offer than limiting issuers to two non-standardized options per network type, metal level, and service area. Further, while we do believe CMS should seek to limit the number of plan offerings, we also believe that limiting issuers to two non-standardized options as proposed will have a variety of unintended consequences with negative impacts on consumers.

First, we wish to note that we believe this proposal may disproportionately impact smaller issuers that offer predominantly HMOs, such as many of ACAP's not-for-profit, community-focused issuers that have a basis in Medicaid. Very few of ACAP's member plans offer both HMO and PPO product offerings, however, many do tend to offer both broad and narrow network offerings. Accordingly, we believe that HMO-only issuers will be disproportionately limited in their ability to stay competitive in the marketplace. Further, if issuers are forced to limit their offerings to two non-standardized options, many will drop their QHPs with broad networks; ultimately moving the market in the direction of skinny network plans with limited provider networks for consumers. In addition, ACAP member plans have stated that in order to remain competitive in this new market they will be forced to drop some of their more innovative products, such as virtual primary care plans, disease specific plans, those that offer supplemental benefits (such as dental and vision) or their high-deductible plans—eliminating plans that may have lower enrollment but that provide strong value for certain consumers. Simply put, while we agree that the number of QHP offerings need to be limited significantly for the benefit of consumers, CMS' proposal puts too much emphasis on simplification of decision-making and not enough on ensuring that available coverage offerings meet consumers' varied needs. Finally, based on feedback from ACAP's member issuers, we believe there may be a disproportionate impact on the number of plan offerings being cut in rural versus urban areas and we urge CMS to evaluate this before finalizing any proposal.

To illustrate the impact this proposal will have on actual offerings we share the following example. Some ACAP member plans offer the following types of silver QHPs alone—not including CSR variant plans: 1) federal standard option, 2) a low-deductible plan, 3) a low-premium plan, plus each of those three options but with supplemental benefits such as adult dental, adult allergy testing, vision, or fitness—bringing the total to six QHP variants. This does not include, for example, any offerings that may be specially-integrated with a local health system, are high-deductible plans, are disease-specific care management plans, or any differences in networks—such as having a skinny and a broad offering, bringing the total even higher—but all with value to different consumers. In the above example the issuer will likely be forced to eliminate their supplemental benefits – a real loss for consumers. Other ACAP members have said they will eliminate their more innovative but less broadly popular QHPs, as well as their QHPs with broad networks, as they must be able to stay competitive for market share with low-cost premiums. Another ACAP member states it will eliminate a telehealth-first primary care plan. And yet another ACAP member has a QHP with reduced primary care coverage cost-sharing (although no difference in network among its other offerings), which it will be forced to drop.

We believe there are a number of solutions that would better resolve the issue of plan choice overload. First, as CMS notes, we believe there is an avenue to reduce the risk of plan choice overload by focusing on enhancing the choice architecture on healthcare.gov; ACAP believes that additional emphasis that can be placed on the decision-making process, better enabling consumers to understand the variety of options available to them and helping them make an educated decision. First, CMS’ display term “easy pricing” may not make it clear to consumers that such plan offerings all have the same design, prescribed by CMS. CMS could better label the filter and provide consumers with other filter options that would allow them to prioritize QHPs with supplemental benefits, or prioritize by lower deductible, or even prioritize by cost-sharing type and amounts. In Massachusetts, for example, during the plan preview period issuers have been able to request pop-up fields on the Connector website, for fields that the issuers believe could be better explained to the consumer. We urge CMS to integrate this into healthcare.gov, so that consumers can gain a better understanding of the differing products and terms they may not be familiar with. Finally, we wish to note that agents, brokers, and navigators should be able to help consumers understand the variety of options, limiting CMS’ concern that such enhancements would only help the consumers who apply for coverage through healthcare.gov.

CMS could also consider other ways of limiting plan options, such as limiting non-standardized option only for silver products, of which—as CMS notes—there tends to be a proliferation, while at the same time silver plans provide the most value for low-income consumers, who tend have the lowest health literacy. We do agree with CMS’ assessment that having an excessive number of plans at the silver level is an important health equity issue, as it places an inequitable burden on those who need insurance the most, who face the greatest challenges in selecting the most suitable health plan, and who can least withstand the consequences of choosing a plan that costs too much and delivers too little.

If CMS does limit non-standardized options, we urge inclusion of additional characteristics and factors that would help mitigate some of the issues raised above. Specifically, we would urge CMS to limit the number of non-standardized plan options not by product network type, but rather by network breadth as well as offerings with and without supplemental benefits. We believe these two changes would go a long way toward mitigating a number of the concerns raised above.

Alternatively, CMS could choose a slightly higher-number limit than two. Any suggestion we can make as to an appropriate limit of offerings is somewhat arbitrary, without the full picture of CMS’ knowledge on plan design offerings. However, we believe more than two is appropriate in order to not stifle innovation and to ensure consumers varied needs can be met—particularly when it comes to supplemental benefits and network breadth. For reference, in 2022, ACAP members offered an average of one catastrophic QHP, nine bronze QHPs, nine silver QHPs, six gold QHPs, and three platinum QHPs, with a median of three bronze and gold QHP offerings and four silver QHP offerings.

Finally, as CMS also acknowledges, it could instead limit plan choice by reinstituting a meaningful differences standard. ACAP has long advocated for a stronger meaningful differences standard (in the 2015, 2017, 2019, and 2023 Payment Notices), before it was eliminated altogether in the 2019 Payment Notice. As early as the 2015 Payment Notice ACAP advocated for a stronger meaningful difference standard than proposed by CMS. In fact, in ACAP's response to the 2015 Letter to Issuers, ACAP commented that:

“ACAP member plans strongly support CMS’ proposed approach to ensuring meaningful difference among different plans from an issuer. Feedback from member plans is that the proposed amounts of \$50 for deductibles and \$100 for out-of-pocket maximums should be increased. Additionally, difference in premium is listed as one category for meaningful difference, but no amount is specified. Ensuring such differences will provide health care consumers with clearer options and will prevent confusion as they shop for coverage.”

More recently, especially with the recent proliferation of plan choices, ACAP has advocated for CMS to reinstitute a meaningful differences standard—but again, stronger than originally proposed. Accordingly, CMS has now proposed an alternative option—imposing a new meaningful difference standard that is based solely on deductible amounts varying by at least \$1,000. While we believe this approach is a step in the right direction, we also believe that, as proposed, it is a rather blunt instrument that will not have the intended consequences. Specifically, we do believe that some of the other characteristics originally included in the meaningful differences standard are important. For example, some consumers may seek out plans that have only co-payments rather than co-insurance, however, that alone as a difference would not necessitate a \$1,000 difference in the deductible. Other consumers may want a choice between a narrow or broad network; however, a different network does not necessarily equate to a \$1,000 difference in deductible, thereby making it difficult for issuers to offer both options. Similarly, as mentioned previously, one issuer offers two QHPs with the same network, but one that has lower cost-sharing for a subset of providers—this option too would not necessitate a \$1,000 difference in deductible. Accordingly, we urge CMS to move ahead with a re-thought-out meaningful differences standard. CMS could consider combining the different characteristics to create a stronger standard such as, for example, a \$500 deductible difference along with a difference in cost-sharing or difference of network breadth by a given amount. CMS has conducted a number of interviews and workgroups looking at standardized options and we urge CMS to similarly create a workgroup to consider a reevaluated set of meaningful difference standards.

Regardless of how CMS chooses to limit the QHP offerings, we urge a phased in approach. Under both of CMS' proposals, over a quarter of all consumers could expect to have their health plan eliminated next year. ACAP believes this could erode consumer confidence in the Marketplace, creating a huge operational burden for issuers that must not only crosswalk their offerings to new products but send discontinuation notices likely to exacerbate consumer confusion. In a year when millions of consumers are expected to lose their Medicaid coverage during the “unwinding,” we urge CMS to not immediately thereafter force a discontinuation of

one quarter of Marketplace enrollees QHPs. ACAP believes this could have an extremely disruptive impact on consumers who are new to the Marketplaces and navigating private insurance coverage for the first time. Accordingly, we urge CMS to slowly phase in any new limitations over multiple years.

While ACAP very much agrees that plan choice overload in the Exchanges is a problem that needs to be addressed, we object to CMS' proposed limitations on non-standardized plan options; we do not agree with CMS' assessment that limiting issuers non-standardized plan options as proposed will ensure a sufficiently diverse range of plan offerings that are innovative or meet a variety of consumers unique health needs. ACAP urges CMS to consider additional options, including improved plan choice architecture, changing the requirement from provider network type to network ID, allowing additional non-standardized plan options with supplemental benefits, or a re-thought-out meaningful difference standard. ACAP believes that a strong meaningful difference standard is overarchingly a better approach than simply limiting non-standardized options as proposed, however, we do not believe that CMS' proposal of using a \$1,000 difference in deductible as the standard for meaningful different plans hits the mark either and urge CMS to consider additional options, which are detailed herein. Finally, ACAP urges a phased-in approach regardless of which proposal to limit QHPs that CMS decides to move forward with.

Plan and Plan Variation Marketing Name Requirements for QHPs

CMS proposes to require that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include misleading content. ACAP's member plans believe it is important for them to be able to name plans in a manner that allows the issuer to highlight unique components of their offerings, while at the same time agreeing that they must be fully accurate and not misleading to consumers. With the advent of standardized plans, and a proliferation of issuers offering the same standardized plan, it is important for issuers to be able to show consumers what makes that particular QHP unique in a sea of options. We do, however, also fully support that such names be accurate and fully support CMS' proposal to verify that plan names are wholly accurate and not misleading to consumers.

ACAP believes that issuers should have the ability to name plans in a manner that allows the issuer to highlight unique components of their offerings. However, ACAP supports CMS' proposal to verify that plan names are accurate and not misleading to consumers.

Plans That Do Not Use a Provider Network: Network Adequacy and Essential Community Providers

CMS proposes to revise the network adequacy and essential community provider (ECP) standards to state that all individual market QHPs and SADPs and all SHOP QHPs across all Exchanges must use a network of providers that complies with established regulatory standards, removing the exception that such minimum requirements do not apply to plans that do not use a provider network. ACAP's member plans do not generally offer SADPs, so our comments are

limited to QHPs. We are fully in support of CMS’ proposal to remove the exception stating that a plan that doesn’t use a provider network is not required to comply with network adequacy standards. Like CMS, we do not believe it is possible to comply with statutory requirements without a provider network and support this change as proposed.

Without a provider network and the protections against balance billing that go along with negotiated rates, consumers purchasing a plan without a provider network are at greater risk of surprise bills and, ultimately, medical debt.

Furthermore, as CMS notes, the ACA notes that an Exchange may certify plans only if it determines that making plans available through the Exchange is in the interests of qualified individuals. We strongly believe that a plan without a provider network is not in the interests of consumers shopping for a QHP. Specifically, without a provider network, consumers are at risk of high out-of-pocket costs, including for preventive services that, according to the ACA, must be covered without cost sharing. In fact, we believe that a plan without provider network protections is akin to so-called “junk insurance” – or non-compliant plans such as short-term, limited-duration insurance (STLDI) and health care sharing ministries (HCSMs), which ACAP has long advocated against (see *Association of Community Affiliated Plans v. The U.S. Department of Treasury*)². While products without a provider network may not have the same history and track record of abuse and lack of consumer protections as the aforementioned, we believe that the risks posed to consumers are great and should not be permitted as a requirement of QHP certification.

ACAP fully supports CMS’ proposal to remove the exception stating that a plan that doesn’t use a provider network is not required to comply with network adequacy standards. We believe that a plan without a provider network is not in the interest of consumers shopping for QHPs and can put them at risk for high out-of-pocket costs.

Compliance With Appointment Wait Time Standards

CMS notes that compliance with appointment wait time standards will begin in 2024. As with our comments in the 2023 Payment Notice, we urge CMS to delay implementation of the new standards by at least one year. Issuers are still, in many cases, struggling to come into compliance with 2023’s time and distance standards due to difficulties in provider network contracting. Accordingly, we urge CMS to delay implementation for an additional year, providing issuers greater time and flexibility to negotiate provider contracts.

ACAP urges CMS to delay implementation of the new appointment wait time standards by at least one year.

Essential Community Providers

CMS proposes to expand access to care for low-income and medically underserved consumers by strengthening essential community provider (ECP) standards for QHP certification. CMS

² Court filings available at www.stopjunkinsurance.com

would establish two stand-alone, facility-based ECP categories: Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers, which would require issuers to offer a contract in good faith to at least one of each of the two new categories. ACAP members are working to ensure robust access to mental health services and SUD treatment with many plans offering dedicated case management and direct outreach to enrollees, at the same time working closely with members to address housing insecurity, food insecurity, and transportation issues that can act as barriers to mental health and SUD treatment. At the same time, ACAP's member plans have a variety of strategies to develop robust providers network, including through telehealth, working with behavioral health services organizations, direct outreach to non-participating providers whose services are being utilized by members, and other forms of network monitoring. Given the critical role of access to mental health and SUD treatment as a part of whole-person health, ACAP supports CMS proposal to add these two additional categories to the ECP requirements.

CMS also proposes to require QHPs contract with at least 35 percent of available federally qualified health centers (FQHCs) and Family Planning Providers in their service area. In general, ACAP's member plans have a robust network of ECPs, given that many are owned and operated by FQHCs or other safety net providers, still others are community owned and operated (the ACA-established Co-Ops), and all are not-for-profit, mission driven issuers focused on serving low-income and vulnerable populations. We wish to note that some ACAP members have had network adequacy and contracting challenges due to provider consolidation issues, particularly with large systems buying up the smaller providers in a given area and refusing to negotiate contracts in good faith. Some ACAP member plans have also experienced difficulty contracting with certain ECPs—Family Planning Providers in particular—and are concerned about ability to meet additional standards. However, with the current justification process in place, ACAP members still overwhelmingly supportive of CMS' proposal to require that issuers meet an overall 35 percent ECP threshold as well as a separate 35 percent threshold for these additional categories.

ACAP supports CMS' proposal to add Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers as categories to the Essential Community Provider (ECP) requirements. We also support CMS' proposal to require that issuers meet an overall 35 percent ECP threshold as well as a separate 35 percent threshold for federally qualified health centers (FQHCs) and Family Planning Providers so long as CMS retains its current justifications process for issuers who are unable to meet the standard.

Termination of Coverage or Enrollment for Qualified Individuals

Establishing a Timeliness Standard for Notices of Payment Delinquency

CMS proposes to add a timeliness standard to the requirement that issuers send a notice of payment delinquency to enrollees, to ensure that such notices are sent in promptly and without undue delay and seeks comment on an appropriate time and manner of sending delinquency notices. ACAP's member plans generally inform consumers that they have entered their grace period / are in a time of payment delinquency through a variety of modes, including telephone,

email, and regular mail. ACAP's members generally notify consumers, at the very least, by including notice of delinquency on a consumer's monthly invoices. Accordingly, ACAP recommends that CMS institute a minimum requirement that issuers include notice of delinquency on their monthly invoices as soon as the first missed payment, while allowing issuers to continue to send additional notices using additional methods.

ACAP recommends that CMS institute a minimum requirement that issuers include notice of delinquency on their monthly invoices as soon as the first missed payment and allow issuers to continue to send additional notices using additional methods.

Conclusion

ACAP thanks CMS for its willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfooster@communityplans.net).

Sincerely,

/s/

Margaret A. Murray
Chief Executive Officer

**UNITED STATES OF AMERICA
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment
Parameters for 2024
Agency Docket No. CMS-9899-P, RIN 0938-AU97**

**Comments of the Federal LGBTQI Health Policy Roundtable and the LGBTQIA+
Primary Care Alliance**

Pursuant to the Department’s December 21, 2022, notice, 87 Fed. Reg. 244, the Federal LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance submit these comments on the Department of Health and Human Services (hereinafter HHS or the Department) and Centers for Medicare & Medicaid Services (CMS) Notice of Benefit and Payment Parameters for 2024 under the Patient Protection and Affordable Care Act (ACA).

Table of Contents

Interest and Expertise of Commenters	2
Comments	2
Payment HCC for Gender Dysphoria.....	2
Repeal of Prohibitions on Door-to-Door and Other Direct Contacts.....	7
Regarding Providing Correct Information to the FFEs (§ 155.220(j))	9
Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))	10
Regarding Failure to File and Reconcile Process (§ 155.305(f))	10
Regarding Income Inconsistencies (§§ 155.315 and 155.320)	11
Annual Eligibility Redetermination (§ 155.335).....	11
Special Enrollment Periods (§ 155.420)	11
Plan Display Error Special Enrollment Periods (§ 155.420(d)).....	12
Prohibition of Mid-Plan Coverage Termination for Dependent Children Aging Out	12
Limitations on the Number of Non-Standardized Plans	12
Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235).....	12
Pricing Adjustment for the Hepatitis C Drugs	13
Conclusion	14

Interest and Expertise of Commenters

The Federal LGBTQI Health Policy Roundtable is a coalition of community health centers and national advocacy organizations that share a focus on laws and policies that affect the health well-being of lesbian, gay, bisexual, transgender and nonbinary, queer, and intersex (LGBTQI) populations. Individually and collectively, our organizations work with agencies and offices within the Department – and with other parts of the Administration – to promote legal reforms and federal policies that advance the health and dignity of sexual and gender diverse people. Our community health center members provide primary health care, gender-affirming care, HIV specialty care, and mental health and substance use treatment services to many tens of thousands of individuals and families, many of whom identify as lesbian, gay, bisexual, transgender, queer, or nonbinary. These centers have years of experience helping patients navigate the complexities of the ACA and the health insurance marketplaces and to enroll in Qualified Health Plans (QHPs). Our membership also includes national advocacy organizations representing LGBTQI communities throughout the country.

The LGBTQIA+ Primary Care Alliance includes Federally Qualified Health Centers (FQHCs), State Primary Care Associations, community health centers, and other health care organizations and providers throughout the nation. Alliance members specialize in best practices for providing culturally responsive and compassionate health care and related services for persons identifying as lesbian, gay, bisexual, transgender and gender diverse, queer, intersex, and/or asexual or on the ace spectrum (LGBTQIA+). The Alliance members joining in these comments collectively serve several hundred thousand individuals and families every year, in the Northeast, Mid-Atlantic, Midwest, South, and West. Our members also advocate for federal, state, and local laws and public policies that advance the health and well-being of sexual and gender diverse people, with particular emphasis on persons of color, immigrants, people with disabilities and chronic illnesses, low-income individuals and families, transgender and gender diverse persons, sex workers, drug users, and other particularly marginalized communities.

Comments

Payment HCC for Gender Dysphoria

We appreciate the opportunity to respond to the request for information on a possible payment Hierarchical Condition Category (HCC) for gender dysphoria. Gender dysphoria is a recognized medical condition that can seriously affect the health and well-being of transgender people. While we share the goal of ensuring that people with gender dysphoria can access coverage for the medically necessary health care services they need—which are robustly supported by the scientific literature and more than five decades of medical practice—we do not believe that an HCC for gender dysphoria is likely to serve that goal under current circumstances in the U.S. health care system. We are also concerned that risk adjustment for gender dysphoria may inappropriately reinforce the perception that transgender identity should inherently be pathologized as a medical

condition, rather than as a natural variation in human identity and experience. We therefore do not support further consideration of such an HCC at this time.

In considering the appropriateness of risk adjustment for gender dysphoria, we referred to the ten principles outlined by CMS in the 2014 Notice of Benefit and Payment Parameters Rule. Below we discuss each of the principles that led us to determine that an HCC for gender dysphoria is not warranted at this time.

Principle 1—Diagnostic categories should be clinically meaningful. Gender dysphoria is recognized as a serious medical condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD), as well as by every major U.S. medical professional association. The primary means of coding for gender dysphoria in the U.S. is a series of mental health condition codes (F64.x) in the 10th edition of the ICD (ICD-10). A history of discriminatory insurance exclusions for the treatment of gender dysphoria, however, has long discouraged U.S. clinicians from using these codes, and some clinicians have resorted to using non-specific codes such as E34.9 (endocrine disorder, unspecified) to capture a need for gender-affirming care without flagging the patient as transgender. While there are indications that the F64.x series codes are being used more often as blanket exclusions of coverage for gender-affirming care receded over the past decade, the current political landscape in the U.S. is increasingly hostile to transgender people and their health care needs. As such, it is impossible to determine whether coding practices will reliably move in the direction of more consistent and accurate coding for gender dysphoria, or whether these codes will once again be avoided by many clinicians and patients—potentially in differential patterns based on state laws—for fear of triggering a transgender-specific coverage exclusion or disclosing a patient’s transgender identity to state authorities.

Further, in the continuing absence of patient self-reported data on transgender status in most U.S. health care organizations, some clinicians append codes for gender dysphoria to claims for encounters where care is provided to a transgender person for purposes other than gender affirmation. The misapplication of these codes merely to identify a transgender person rather than to indicate the provision of a service to treat gender dysphoria dilutes the clinical relevance of these codes for risk adjustment purposes.

Finally, the existing codes do not differentiate among appropriate treatment courses for gender dysphoria or incongruence and thus do not specify uniform clinical trajectories that would justify risk adjustment. The expert *Standards of Care for the Health of Transgender and Gender Diverse People* (Version 8, 2022)¹ emphasizes that the course of care for gender dysphoria is highly individualized and that determinations of medical necessity should be made by providers in close consultation with individual patients: while some people with gender dysphoria may need mental

¹ World Professional Association for Transgender Health. (2022). *Standards of Care for the Health of Transgender and Gender Diverse People* (8th Version). 23 Int’l J. Trans. Health Supp. 1. <https://doi.org/10.1080/26895269.2022.2100644>

counseling, hormone therapy, and surgeries, others may need only some or none of these services. The course of care for gender dysphoria is also very different not only between individuals but by age: for pre-pubescent children, the only medical intervention that may be indicated is mental health counseling to assist the child and their family in exploring the child's gender through non-medical interventions such as social support. For adolescents, gender affirmation may include mental health support as well as puberty delay medications and eventually exogenous hormone therapy; surgeries are generally not indicated for adolescents and are only performed very rarely and in the presence of severe and debilitating gender dysphoria that is not alleviated by other care alone. For adults, the course of gender-affirming care may include a combination of mental health support, hormone therapy, and surgeries.

In the F64.x code series in the ICD-10, however, while support for children with gender dysphoria is captured in the code F64.2 (gender identity disorder of childhood), care for adolescents versus adults and between patients with differing degrees of clinical severity is not differentiated by the F64.0 (transsexualism), F64.8 (other gender identity disorder), and F64.9 (gender identity disorder, unspecified) codes. The ICD-11 code series maintains this approach with the codes HA60 (gender incongruence of adolescence or adulthood), HA61 (gender incongruence of childhood), and HA6Z (gender incongruence, unspecified). Moreover, the ICD-10 codes currently in use in the U.S. to describe the presence of gender dysphoria or a need for gender-affirming care also include the highly non-specific codes Z87.890 (personal history of sex reassignment) and F64.1 (dual-role transvestism).

For these reasons, we do not believe that coding for gender dysphoria/incongruence as reflected by the DSM-5, ICD-10, or ICD-11 frameworks currently captures discrete clinical trajectories to a degree sufficient to justify risk adjustment under this principle.

Principle 2—Diagnostic categories should predict medical expenditures. Putative claims of higher health care costs are routinely used against transgender people to argue that coverage for gender dysphoria is a burden on the health care system and should be restricted or eliminated. The available evidence shows, however, that removing exclusions of coverage for gender dysphoria from insurance plans is cost-neutral or extremely low-cost. The City and County of San Francisco initially raised premiums when they became the first major U.S. employers to remove blanket exclusions for gender-affirming care in 2001. But after five years, “beneficial cost data led Kaiser and Blue Shield to no longer separately rate and price the transgender benefit—in other words, to treat the benefit the same as other medical procedures such as gallbladder removal or heart surgery.”² A 2013 survey of employers providing coverage for gender-affirming care to their employees found that two-thirds of the employers that provided information on the actual costs of utilization of gender dysphoria treatments reported zero costs, and those employers who reported

² City and County of San Francisco Human Rights Commission, *San Francisco City and County Transgender Health Benefit* (Aug. 7, 2007), https://transhealthproject.org/documents/19/SF_transgender_health_benefit.pdf

some costs said that the costs were very low or minimal.³ An analysis of gender-affirming care uptake by transgender people over 6.5 years in one California health plan found a utilization rate of 0.062 per 1,000 covered persons.⁴ Estimates from other states show equally low utilization and related low costs, with North Carolina estimating costs at 0.011% to 0.027% of premiums;⁵ Alaska, 0.03% to 0.05%;⁶ and Wisconsin, “immaterial at 0.1% to 0.2% of the total cost.”⁷ Cost estimates under Wisconsin Medicaid were “actuarially immaterial, as they are equal to approximately 0.008% to 0.03%”⁸ of Wisconsin’s share of its Medicaid budget. Similarly, an analysis in the military context concluded that the financial cost of covering gender-affirming care was “too low to matter”⁹ or, as military leadership noted, “‘budget dust,’ hardly even a rounding error.”¹⁰ This is because only a small percentage of the U.S. population is transgender, and, as noted above, not all transgender people need or use a full scope of services related to the treatment of gender dysphoria.

While we support continuing research to better understand patterns of utilization and expenditures in relation to gender dysphoria, we note that efforts to conduct this research can be susceptible to inherent bias that stems from the fact that, in the absence of self-reported demographic data on transgender status that can be linked to claims data, transgender people can only be identified through encounters with the health care system that result in the generation of claims and related costs. As such, claims data analyses may paint a distorted picture in which transgender people appear to use more health care services and incur higher costs in comparison to people who may have very low or zero utilization and who are presumed to be cisgender due to the absence of codes for gender dysphoria. Any future analyses assessing possible relationships between gender dysphoria and health care costs should rely on self-reported data on transgender status so that transgender and cisgender enrollees can be fairly compared, and they should use long time horizons and incorporate potential cost-savings in long-term mental health and surgical needs that may be realized by timely treatments such as puberty delay medications in adolescence.

³ Herman JL, The Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings From a Survey of Employers* (Sept. 2013), <https://escholarship.org/content/qt5z38157s/qt5z38157s.pdf?t=n2ff2l>.

⁴ State of California Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, Reg. File No. REG-2011-00023 (Apr. 13, 2012), at 5, <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>

⁵ Segal Consulting memorandum to Mona Moon, Executive Administrator of the North Carolina State Health Plan, re: Transgender Cost Estimate, Nov. 29, 2016, <https://files.nc.gov/ncshp/documents/board-of-trustees/3aai-3-The-Segal-Company-Transgender-Cost-Estimate-Memorandum.pdf>

⁶ Plaintiffs’ Motion for Partial Summary Judgment, *Fletcher v. Alaska*, No. 1:18-cv-00007-HRH (D. Alaska July 1, 2019), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/fletcher_ak_20190701_plaintiffs-motion-for-partial-summary-judgment.pdf

⁷ *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018).

⁸ *Flack v. Wis. Dept of Health Servs.*, 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).

⁹ Belkin A. Caring for our transgender troops – The negligible cost of transition-related care, 2015 *New Eng J Med* 373:1089-1092, at 1092, <https://www.nejm.org/doi/full/10.1056/NEJMp1509230>.

¹⁰ Declaration of Raymond Edwin Mabus, Jr., Former U.S. Secretary of the Navy, in Support of Plaintiff’s Motion for Preliminary Injunction, *Doe v. Trump*, No. 17-cv-1597-CKK (D.D.C.) filed Aug. 31, 2017, at 41), available at <http://files.eqcf.org/wp-content/uploads/2017/09/13-Ps-App-PI.pdf>

Principle 3—Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures. Transgender people are estimated to make up less than 1% of the U.S. population.¹¹ In claims data analyses, the prevalence of people presumed to be transgender based on the presence of codes for gender dysphoria is typically a tiny fraction of a percent.¹² When these already small cohorts are broken down by age to more accurately reflect potential differences in expenditures, the sample sizes for predicting costs become even smaller. Widespread and consistent collection of demographic data on transgender status, as recommended by a 2022 report from the National Academies of Sciences, Engineering, and Medicine,¹³ and linkages of these data with information on health care utilization and expenditures are needed to even begin to build sample sizes that would be sufficient to satisfy this principle.

Principle 10—Discretionary diagnostic categories should be excluded from payment models. As discussed in relation to Principle 1, a great deal of variation currently exists in the degree to which clinicians are aware of the appropriate application of codes for gender dysphoria treatment. Moreover, given elements of the current U.S. political environment that increasingly threaten the safety of transgender people and the providers who care for them, coding practices are unlikely to soon stabilize across age groups, states, and insurance programs. Until transgender people are afforded sufficient protection from discrimination in health coverage and care—and until their health care needs are correctly viewed as legitimate and justified on the basis of the scientific literature that has established the medical necessity of this care—gender dysphoria codes will continue to be treated by providers and patients alike as not only discretionary but potentially dangerous.

Finally, we note that there is no inherent relationship between gender dysphoria/incongruence and any other diagnoses, which the ICD-11 further emphasized by moving gender incongruence from the mental and behavioral health chapter to a separate chapter on “conditions related to sexual health,” where the only other entries are sexual dysfunctions and sexual pain disorders. Given the lack of a meaningful clinical relationship between gender dysphoria/incongruence and other conditions in the ICD-10 and ICD-11, these codes should not be combined with other diagnoses to form a broader HCC that is inclusive of gender dysphoria.

¹¹ Herman JL, Flores AR, O’Neill KK. (2022). How Many Adults and Youth Identify as Transgender in the United States. Los Angeles: The Williams Institute. <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>

¹² See, e.g., Jasuja GK, de Groot A, Quinn EK, et al. Beyond Gender Identity Disorder Diagnoses Codes: An Examination of Additional Methods to Identify Transgender Individuals in Administrative Databases. *Med Care* 2020;58(10):903–11.

¹³ National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring Sex, Gender Identity, and Sexual Orientation*. Washington, DC: National Academies Press. <https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation>

In sum, as long as transgender people continue to be the targets of state-sanctioned mistreatment and exclusion in health coverage and care, the primary means of ensuring access to gender-affirming care must be robust nondiscrimination protections that apply and are enforced nationwide. A strong bulwark of laws and policies protecting transgender people from discrimination in health care and coverage, as well as clear indications that regulators and carriers in states across the country understand and respect the medical necessity of gender-affirming care, are necessary prerequisites for any further consideration of an HCC for gender dysphoria.

Repeal of Prohibitions on Door-to-Door and Other Direct Contacts

We support lifting the prohibition of door-to-door canvassing by Navigators and Assistors. Whitman-Walker Health, (WWH), an LGBTQ+ serving FQHC in the Washington, DC area, has offered navigation services since before the ACA was implemented. We highlight their services as one of the nation's longest-running navigation providers.

We agree that door to door canvassing should include non-navigator assistance personnel – sending highly trained Assistors/Navigators door to door is not an efficient use of resources but using non-Navigator support personnel help achieve community outreach and education goals and facilitates effective connections to Navigators via “warm hand offs” from educators to Assistors/Navigators. In recognition of their expanded role in assisting patients and clients in accessing social and health care services, these comments also call Navigators and Assistors, “Patient Benefit Insurance Navigators” (PBINs),

We support the view that repealing restrictions on an Exchange's ability to allow Navigators, non-Navigator assistance personnel, and certified application counselors to offer application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact is a positive step that would enable Assistors to reach a broader consumer base in a timely manner—helping to reduce uninsured rates and health disparities by removing underlying barriers to accessing health coverage.

As part of an integrated service model, the PBIN team serves an important role to help ensure access to care by removing or addressing barriers to care from insurance or lack of insurance issues or cost of care issues. Specifically at WWH, the PBIN team helps WWH patients and DC area residents with health insurance eligibility, enrollment, and literacy, connecting people to Medicaid, Medicare, and Qualified Health Plans on the exchange, subsidies, and other insurance options for which they may be eligible. The PBIN team serve as certified DC Health Link Assistors, providing critical consumer outreach and enrollment assistance to uninsured and under-insured DC residents. Given WWH's patient population and geographic location, the PBIN team also counsels clients from Maryland and Virginia and receives calls from other areas for assistance and advice. The PBIN team works across three sites and manages an Insurance Helpline (where callers get immediately connected to a navigator for assistance). These avenues ensure that the navigators connect promptly and efficiently so that they can screen all patients and area consumers for eligible

insurance coverage, assist them in applying for benefits as applicable, and handle and resolve any eligibility or coverage issues.

Evidence shows that millions of people find the process of applying for and using health insurance overwhelming. Many lack basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including Black, Indigenous, and other communities of color. Questions and problems accessing care are not limited to the eligibility and enrollment issues. And with many people seeking assistance qualifying for Medicaid or subsidies, issues are not limited to open enrollment periods.

WWH's insurance navigation services are year-round services by trained experts who can help consumers break down barriers and promote access and health insurance literacy. Given this, it is vital that funding and the scope of services of Navigators include eligibility and enrollment, counseling and all the post-enrollment and access activities highlighted. We support expanded funding for Navigator services and ask that HHS intentionally recognizes that PBINs are trained experts on complex systems and supporting the professional development of expert navigators through year-long employment improves efficiency and supports innovation. Additionally, professional navigation should be available year-round to support continuous enrollment, special enrollment periods (SEP), and the full life cycle of consumers years as qualifying events occur. Funding only for open enrollment often results in temporary, seasonal jobs. Temporary employment misses the life cycle of qualifying events and fails to take advantage of the expanded access to SEPs proposed within the notice.

The Biden Administration has been supportive of market reforms that facilitate patient access to health insurance marketplaces, but navigator services are still not emphasized in a way that reflects their essential importance to consumer access. PBINs are service delivery and workforce specialists who unlock access to much needed health care services. As described briefly above, they operate year-round on the front-line of our operations, conducting more than just eligibility and enrollment screenings. PBINs also screen clients and patients for other needs, including health-harming legal issues that affect social determinants of health, like housing, employment, and education, and health related social needs like food security, transportation, and income. Given our focus on the LGBTQ community, PBINs also screen for alignment with name and gender marker on identity documents to ensure being asked for your insurance card and identification at a health visit isn't creating a barrier for people.

Expert navigators are trained to screen for social determinants of health and legal issues in the natural course of conversation when enrolling patients and clients, and to identify upstream issues to improve health. WWH navigation services are available in Spanish, English, and Amharic and are an essential part of a culturally competent practice. Screening for these additional barriers is organic, as the PBINs have much of this information from their screening for health insurance options - income, family size, immigration status, name, gender marker, employment status,

housing status. By using that information to identify potential other needs, the PBINs serve as a "upstream screener" and connector to other services like legal services who can assist to break down other systemic barriers critical to increased patient engagement, empowerment of consumers, and improving overall health care delivery. Conducting insurance navigation helps build health insurance literacy for our diverse patient population, helps give providers more care options when patients are insured, and helps our health center have stronger financial stability and long-term sustainability.

It is our experience that no matter someone's education, age, or computer literacy, people need navigation services. Despite the reforms that we have seen increasing enrollment periods, expanding tax credits for enrollees, protections from renewals and terminations of Medicaid during the COVID-19 public health emergency (PHE), and expansions of insurance coverage, consumer needs for Navigation services remain high and we are as busy as ever helping people navigate the very complicated health care system.

We support the proposal that changes rules to allow sharing information with Navigators of consumers who have been determined ineligible for Medicaid. The NPRM makes clear that consumers may only be approached when ineligible for Medicaid. Unfortunately, this regulation misses the opportunity to leverage PBIN expertise to support re-enrollment. Navigators need to be able to talk eligibility across options and engage by helping consumers to recertify Medicaid or discuss life events – new job/higher income, family size shift, etc – that may change eligibility. Sharing of information should be seen as part of supporting a “no wrong door” policy and a coordinated, robust screening process.

We support the change to allow Assisters and Navigators to offer application assistance door-to-door and through other unsolicited means at this stage of the implementation of the ACA. We agree that now that the Exchanges and their Assister programs have been in operation for almost 10 years, Assisters have more name recognition and consumer trust within the communities the Assisters serve. Accordingly, HHS believes that its previous concerns related to consumers' privacy and security interests and consumers not knowing what to expect when interacting with Assisters have been sufficiently mitigated with the measures HHS has enacted such that a blanket prohibition on unsolicited direct contact of consumers by Assisters for application or enrollment assistance is no longer necessary.

Regarding Providing Correct Information to the FFEs (§ 155.220(j))

We support a statutory requirement to

“...explicitly require agents, brokers, or web-brokers assisting consumers with completing eligibility applications through the FFEs and SBE-FPs to confirm with those consumers the accuracy of the information entered on their applications prior to application submission or document the consumer has reviewed and confirmed the information to be accurate.”

This regulation reasonably incentivizes the agent to take due care when engaging with clients and establishes a duty to confirm the information with the consumer. The rule seems likely to improve the accuracy of the information received in applications by establishing a second level of review and is constructed to support consumer-driven and informed consent of consumers as well.

The requirements on the documentation of consent seem carefully calibrated to balance the need for ease of understanding, storage of the information, and creating incentives for agents and brokers to explore and innovate new best practices for their business and the consumers they serve. The minimum standard of keeping records for 10 years helps establish consumer expectations and uniformity across brokers and agents.

Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))

We are concerned about the security of consumer consent records and want to ensure strong data security and data hygiene standards are applied to any potentially sensitive information, including private health data. For example, is the consumer consent documentation kept, but not the underlying consumer application data? What happens to the consent confirmation? Is it encrypted, or otherwise kept physically and digitally secure? How long do brokers retain consumer application data? Under what conditions is this data kept? Large troves of consumer data retained by agencies and brokers represent a substantial risk to consumer privacy, which can be minimized by leveraging emergent best and promising practices on data retention and storage.

Regarding Failure to File and Reconcile Process (§ 155.305(f))

We agree that the costs of the current policy that ends a consumer's coverage are outweighed by the benefits of encouraging robust enrollment and participation in insurance programs. The proposed rule to not terminate because someone failed to file taxes for two years is an excellent addition. As noted, the IRS records may be inaccurate, and it is important that consumers not be improperly removed from a plan due to error on the part of the government.

Additionally, this change supports consumers who may not properly understand the consequences of failing to file, due perhaps historical expectations that lack of income negates the necessity to file taxes. In our practice, many consumers do not fully understand – even with coaching – the relationship between taxes and health insurance. The connection in many minds is non-obvious, complicated, and questionable. Finally, many people file late, some files years late after realizing they need to. This new language is a good relaxation of the original requirement to enhance consumer protections in support of continuity of coverage, and reduce the resources allocated to needless appeals. The proposed rule extending the grace periods instituted during the COVID-19 PHE will give consumers ample time to adjust to new requirements while Navigators and Assistors implement HHS's new flexibilities to engage in consumer education and the new requirements

that support accurate reporting of consumer data, ensuring the efficient administration of HHS resources.

Rather than provide an extra year of flexibility, we suggest that it may further support HHS's objectives to remove the penalty entirely. This would ensure that eligible consumers retain coverage under all circumstances. HHS should consider the impact of eliminating the penalty on the market and if HHS has a less restrictive means of administering the filing requirement. For example, consumers found to be ineligible for APTC could be charged premiums retroactively.

Regarding Income Inconsistencies (§§ 155.315 and 155.320)

We support the proposed regulation allowing self-attestation of projected income and family size in the absence of data from the IRS or when such data from the IRS fails to reflect a change of circumstance that is relevant to a consumer's eligibility for insurance affordability programs. Self-attestation and alternative documentation procedures support, to the greatest extent practicable, the inclusion of potentially eligible consumers in the insurance programs. This is an excellent use of Department resources as a high value is placed on consumer participation in insurance plans and incentivizes the IRS to provide timely information to the Exchange. The added flexibility supports an approach that meets consumers needs and balances the Department's interest in the judicious use of federal funds.

We support the range of additional flexibilities, especially the mandatory extension for consumers to provide documentation supporting their eligibility for advanced premium tax credits (APTCs) and cost sharing reductions (CSRs). Many patients who benefit most from these programs are working in households with multiple sources of income woven together to support a family. These beneficiaries are well-poised to benefit from these changes, and potentially deeply harmed when incorrectly removed from coverage. The additional flexibilities support consumers with the needed time to understand the requested information and gather it from across their household.

Annual Eligibility Redetermination (§ 155.335)

We support the proposed rule directing re-enrollment into lower or same cost, high generosity plans. This proposal is well calibrated to protect consumers who are most likely to need additional support and could benefit from the updated guided auto enrollment rules. As HHS notes, the proposed change will have a protective effect on consumers, likely lowering out of pocket costs while directing consumers to high-value products on the exchanges when they do not actively re-enroll themselves.

Special Enrollment Periods (§ 155.420)

We support the proposed change to requirements to allow a household to enter a special enrollment period based on a single member of that household having a qualifying event. This change supports

inclusion of households with different family structures and access to affordable insurance options for more consumers, especially those who move from Medicaid plans to marketplace plans. This will be particularly important for consumers facing the end of Medicaid enrollment flexibilities upon the expiration of the COVID-19 PHE, which is expected starting April 1, 2023. The proposed change more accurately reflects the lived experiences of consumers, in which often the changed circumstances of a single person within a household are part of a larger ecosystem of resources, income, and insurance products. For example, a qualifying event, like a birth, marriage, or job loss, may require a household to make changes to make certain other changes, and this expansion of SEP supports the lived experiences of many families.

Plan Display Error Special Enrollment Periods (§ 155.420(d))

We support the proposed changes to ensure that errors in Marketplace plan displays do not adversely affect consumers. We believe this change encourages the efficient operations of Marketplaces and the Exchanges while reducing the burden on consumers to prove an error occurred.

Prohibition of Mid-Plan Coverage Termination for Dependent Children Aging Out

We support the proposed prohibition on terminating coverage mid-year for dependent beneficiaries of plans who age out. This proposed change supports the industry standard of enrolling in health plans during the open enrollment periods at the end of each calendar year and creates stability for parents and families during transitions.

We see the coverage gap scenarios that HHS highlights in their NPRM. During the COVID-19 PHE-related SEP, Washington, DC's Marketplace exchange allowed consumers to essentially choose the effective date – not mid-month but retroactive, current, or prospective enrollment. Recognizing that mid-month enrollment is logistically difficult for insurers, an approach that allows for flexibility as to the effective date to meet the needs of consumers is balanced with the need for insurers to efficiently administer their plans.

Limitations on the Number of Non-Standardized Plans

We support the proposed rule to limit the number of non-standardized plans as reasonably designed to produce efficient health exchanges that are understandable and navigable by consumers. This proposed regulation may have a beneficial effect of reducing incentives for insurers to drive consumers from high value products through confusing marketing techniques. Combined with marketplace requirements based on meaningful differences, the proposed change reduces incentives to market a plethora of relatively cheap plans and supports innovation by insurers.

Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

We support the proposed changes to network adequacy and Essential Community Provider (ECP) standards. ECP requirements are a key feature of HHS regulations that ensure vulnerable communities, including low-income communities, LGBTQIA+ people, and communities of color are able to access health care services that are affordable and culturally and linguistically appropriate. Many LGBTQ+ serving health care centers are ECPs, and we support robust requirements that specialized ECPs with specific expertise be included in network adequacy requirements, including the proposed rule to create new standalone classes for ECPs for Substance Use Disorder (SUD) Treatment and Mental Health Facilities. We note that for patient access purposes, it is important that Mental Health Facilities and SUD Treatment centers used to satisfy the proposed requirements include facilities that are secular in nature, as many LGBTQIA+ people and racial and ethnic minority patients report discomfort with religiously affiliated programs.

We support the proposed changes to expand QHP requirements for contracting with Family Planning and FQHC ECPs to a 35% threshold. This ensures that network adequacy requirements result in meaningful coverage for underserved populations.

In the experience of WWH in Washington DC, low-income clients from Virginia and Maryland with exchange plans may find that WWH is excluded from their network because the plan issuer identifies the in-state ECPs, but not those in DC. HHS can provide clarification that a plan's service area and geographic distribution requirements include nearby metropolitan areas. Additionally, we propose a clarification that the threshold requirements do not prohibit adding to the plan's network, just removing providers from a plan's network.

In response to questions about ensuring network adequacy of certified QHPs, we recommend that HHS look to the requirements for Essential Health Benefits (EHBs) sold on state exchanges. The 10 categories of EHBs provide consumers with confidence to understand the quality of the insurance plans they are purchasing and provide market stability for insurers. Consumers would also benefit from plans having up-to-date information on available providers on insurers online network platforms. It may be helpful for consumers to understand whether an ECP is included or covered if the meaningful differences between network robustness is indicated by metal level.

Pricing Adjustment for the Hepatitis C Drugs

The Department's proposed rule to continue a market pricing adjustment specific to Hepatitis C drugs in models for the 2024 benefit year seems reasonably well calibrated to reduce the incentives that issuers will create discriminatory plans to drive away people living with or at risk for Hepatitis C. Virus (HCV). HCV cure therapies represent a breakthrough in HCV treatments as the NPRM notes, the costs are changing rapidly among drug products. A pricing adjustment for HCV drugs encourages formularies with sufficient access to all effective treatments for patients that need them.

Conclusion

The LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance are pleased to participate in this important discussion. We would be happy to provide additional information or to assist CMS or the Department in any other way. For more information regarding any portion of these comments, please contact Benjamin Brooks, Associate Director of Policy and Education at Whitman-Walker Institute via bbrooks@whitman-walker.org.



**Washington
Association for
Community Health**
Community Health Centers
Advancing Quality Care for All

January 30, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

Dear Administrator Brooks-LaSure:

The Association represents our state's 27 Federally Qualified Health Centers (FQHCs) who provide healthcare innovation, access, and value to our communities. Our state's FQHCs provide primary care, behavioral health, dental care, and additional wraparound services to 1.2 million Washingtonians, regardless of insurance status or ability to pay. We have been on the front lines of this pandemic – caring for patients with COVID-19, organizing mass testing and vaccination events in communities across our state, and providing telehealth services to address primary care needs. Community health centers and navigators are key community-based enrollment partners and have experience working with immigrant populations. We are guardians of the safety net population.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. Approximately 18.8% of our patients have private insurance while 55.2% of our patients are on Medicaid coverage.¹ These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, the Association's FQHCs helped many Washingtonians seeking coverage in 2021. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. The Association strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the

¹ <https://data.hrsa.gov/tools/data-reporting/program-data/state/WA/table?tableName=Full>



Administration’s proposed changes in the proposed rule “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

The Association welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; III. Cuts to User Fees; and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

The Association supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)² to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. The Association recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, the Association recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall...include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals.” As the Association has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. The Association recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFM must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”³ but given the crucial role health centers play in delivering primary care services, the Association believes that these good-faith contracts should extend to all FQHC in their service area.

² Section 1311(c)(1)(C)

³ <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

The Association recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate⁴ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like the Association, to engage with states and hold them accountable. The Association recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁵ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Washington’s health centers use their savings through the 340B program to meet the unique needs of our communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, to understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

The Association strongly supports the proposed changes—repealing § 155.21(d)(8) and § 155.225(g)(5)—to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Washington’s health centers leverage their trusted relationship in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Our health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. The Association appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

⁴ Section 1902(bb) of the Social Security Act

⁵ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security>

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. The Association appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

The Association also supports the proposal at § 155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁶ With the median U.S. household income reported at \$70,784 in 2021,⁷ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

The Association also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁸ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

The Association appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs

⁶ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spendin>

⁷ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1>

⁸ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>

for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁹ Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as “billable providers” and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.¹⁰

The Association is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee—a fixed percentage of premium revenue paid by insurers—supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS’ proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹¹ While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹² this

⁹ <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcaregov-open>

¹⁰ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

¹¹ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹² <https://www.medicaid.gov/federal-policy-guidance/downloads/cib010523.pdf>

means States will be continuing to complete these determinations into 2024. In Washington state, approximately 350,000 redeterminations by managed care organizations will occur over the 12-month unwinding period.¹³ These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, the Association believes they should remain at their current percentages: 2.5% in the marketplace, 2.25% in the state-based marketplace. The Association also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{14 15 16} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

The Association supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,¹⁷ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁸ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

¹³ <https://www.hca.wa.gov/assets/free-or-low-cost/apple-health-phe-unwind-enrollment-data.pdf>

¹⁴ Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment—effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹⁵ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁶ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

¹⁷ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁸ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

The Association supports the first CMS proposal § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁹ While many Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, the Association applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and the Association also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. The Association appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

The Association also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. The Association appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

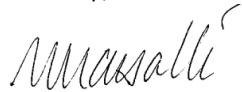
The Association recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

¹⁹ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

Another enrollee protection the Association supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage, and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhancing access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Please contact me with any questions or concerns at (360) 786-9722 ext.224 or BMarsalli@WaCommunityHealth.org.

Sincerely,



Bob Marsalli
Chief Executive Officer
Washington Association for Community Health



January 30, 2023

Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Chiquita Brooks LaSure,

The Colorado Consumer Health Initiative (CCHI) is pleased to provide the Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) comments on the proposed Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters (NBPP) for 2024. CCHI is a nonprofit, consumer-oriented, membership-based health advocacy organization that serves Coloradans whose access to health care and financial security are compromised by structural barriers, affordability, poor benefits, or unfair business practices of the health care industry. We thank CMS for this opportunity to weigh in regarding the proposed revisions to the NBPP and offer the following comments.

CFR Part 155

Documentation of eligibility

We support and appreciate CMS's amendments to the regulations to require brokers, agents, and web-brokers to document that eligibility application information has been reviewed and confirmed accurate by the consumer or their authorized representative. This requirement is in line with [recent proposed regulations in Colorado](#) that would require producers to review and document with the consumer the accuracy of the information used to determine eligibility. This is a crucial requirement, as we have heard anecdotes from consumers who have been misinformed of their eligibility in one way or form during the application process, leading to negative effects and higher costs generally for the consumer. That is a result that must be guarded against and requiring documentation and review of the accuracy of eligibility information would help accomplish that.

Federal Tax Reconciliation

The proposed changes to shift away from a consumer that has not reconciled their taxes for more than a year is beneficial and appreciated. Shifting this to two years of delinquency, as CMS

notes, would allow for greater continuity of coverage and help ensure more consumers can maintain coverage.

Annual Eligibility Determination and Re-enrollments

We strongly support CMS's proposed amendment to allow exchanges to shift automatic re-enrollments for CSR eligible individuals to a silver level plan if currently enrolled in a bronze level plan. Data in Colorado suggests there are a number of enrollees that are CSR eligible that are enrolled in bronze level plans, putting them at significantly higher risk of out-of-pocket costs and medical bills they cannot afford. We also support HHS's consideration of a hierarchy for enrollment that evaluates both net premium and out-of-pocket costs. This would allow the enrollment hierarchy to better guide consumers to plans that are of overall higher value and likely more protective for consumers against unaffordable medical costs.

SEP Clarifications

We strongly support the clarification that if one member of the tax-filing household qualifies for a special enrollment period, the entire household qualifies for an SEP. We support the proposed changes to allow Exchanges to offer earlier coverage effective start dates for consumers that attest to a future loss of coverage. This change will help consumers avoid more significant gaps in health coverage and better maintain their health. We also support the proposed change to allow a consumer affected by a loss of Medicaid or CHIP coverage up to 90 days after loss of said coverage to enroll in Exchange coverage. And, we appreciate the proposed modifications for display error SEPs that would remove the burden from consumers to solely demonstrate to the Exchange a material plan display error influenced the consumer's decision to enroll.

Termination of Coverage

CMS's decision to prohibit issuers from terminating coverage prior to the end of the plan year because a dependent child has reached the applicable maximum age is important to ensure consumers do not lose coverage arbitrarily in the middle of a plan year due to their age.

CFR Part 156

Mitigating Consumer Choice Overload

We support CMS's proposal to limit non-standardized plans being offered through Exchanges to no more than two non-standardized plans per product network type and plan level. In some areas of Colorado, consumers have up to 6 carriers to choose from and are faced with an overwhelming number of plans to choose from. We strongly recommend that this should be layered with HHS's proposal to apply a more stringent meaningful difference standard to ensure. Experience suggests that meaningful difference standards to this point have not been strong enough to prevent issuers from offering plans that do not seem materially different or are not easily distinguishable to consumers in the enrollment process. Applying a more stringent standard is necessary in addition to applying the proposed limit on non-standardized plans. These two mechanisms are complimentary and we urge CMS and HHS to use both in this rule to aid

consumers in their enrollment experience and ensure meaningful and navigable choices for consumers.

Stand Alone Dental Plans

We support the proposed treatment of Stand Alone Dental Plans (SADPs) to use the age on the effective date as the only way to calculate the enrollee's age rating and eligibility purposes as well as requiring SADP issuers to provide guaranteed rates to ensure accurate APTC calculations and protect consumers from unnecessary tax reconciliation.

However, we would urge CMS to consider requiring that dental benefits be embedded rather than offered as stand-alone plans. While premiums for stand-alone adult dental average around \$24 per member per month and pediatric stand-alone plans \$27 per member per month, the American Dental Association's (ADA) Health Policy Institute estimated the premium impact of embedding pediatric dental into a silver level plan, on average, would cost about \$5 per person per month, while average out-of-pocket costs were lower¹ for most consumers when dental was embedded in the qualified health plan. Moreover, they found that plans offering first-dollar coverage (e.g., not subjecting dental services to the overall QHP deductible), typically did not have higher premiums. Requiring dental plans to be embedded provides better coverage with lower out-of-pocket costs and with a lower premium cost. As indicated in our comments on CMS's RFI regarding essential health benefits, there are a number of reasons to require dental to be covered and embedded into QHPs.

ECP Standards

We strongly support CMS's proposed elimination of exceptions for the Essential Community Provider (ECP) standards to ensure all coverage plans under this rule adequately incorporate ECPs. We agree with CMS's proposed requirement of the 35% threshold applying individually to FQHCs and Family Planning Providers. Colorado has bolstered ECP requirements in our Colorado Option plans to 50% as a way to ensure more ECPs are brought into coverage networks, but more importantly, to ensure more equitable access to care. ECPs are often relied upon by low-income consumers and BIPOC individuals as a primary source of care. Ensuring all plans include ECPs is an important mechanism to improve health equity for populations that struggle to access the care they need.

We also support the proposed creation of the stand-alone categories of ECPs for Mental Health Facility and Substance Use Disorder Treatment Centers. However, these new categories of ECPs should meet the same qualifications by serving Medicaid/CHIP/uninsured & underinsured patients.

Timely notice

We agree that consumers should receive timely notice if they are delinquent in payment to their insurance carrier. Creating timeline standards for this would help ensure issuers do not arbitrarily

¹ <https://www.jpeds.com/action/showPdf?pii=S0022-3476%2816%2931275-6>

terminate coverage without providing the enrollee a chance to make a payment that may be needed to maintain their coverage.

Additional Comments

Actuarial Value and Cost-Sharing Limits

Colorado's health coverage innovation through our Colorado Option standardized plans has underscored the significant deficiencies created by the current limitations on actuarial value and cost-sharing within qualified health plans. This results in increasing out-of-pocket costs for Coloradans and people across the country, limiting opportunities for value and equity driven coverage, and ultimately contributes to medical debt and financial instability.

Actuarial Value

The current approach to actuarial value (AV) of EHBs and qualified health plans has led to severe limitations in states' abilities to advance health equity and design higher value plans that better protect people from a medical bill crisis. Colorado recently updated our state benchmark plan, and despite strong evidence for a variety of services that could be integrated with very low or no cost, the constraints of the de minimis range significantly limited our ability to create a more equitable and comprehensive EHB benchmark for the state. This is highlighted by a second substantive deficiency in the approach to AV. The federal AV calculator fails to account for potential savings from providing better coverage of key services that can improve health equity, have a high value, and can ultimately prevent accessing higher-cost acute or emergency care. So, while Colorado has incorporated more basic services like primary care, behavioral health, and perinatal care services with no cost-sharing in our Colorado Option plans, the fact that these services can improve health outcomes, lower overall costs, and address racial and health disparities is not accounted for as a part of the AV calculation. Instead, they are seen through the calculator as increasing the overall value and costs of the plan. Similarly when reviewing our state benchmark in 2021, services that could lead to cost savings or that should likely be considered cost neutral, if not reducing overall costs because of their ability to lower other care costs were still calculated to increase the overall AV of the plan. This combination of the de minimis constraints and the reductive AV calculator virtually prohibit more significant coverage innovation at the state level.

Cost-sharing

To put it plainly, the high level of cost-sharing allowed through ACA plans have made accessing care increasingly unaffordable for people to access. High deductibles and out-of-pocket maximums leave millions of Americans exposed to high medical bills and medical debt and discourages accessing needed care. 1 in 5 Coloradans delayed or skipped medical care because of costs. The high costs of care allowed under ACA regulated plans is contributing to the disparities in medical debt with all Coloradans of color struggling to pay medical bills at one and a half to 2 times the rate of white Coloradans. This disparity is highest among Black and Hispanic/Latino Coloradans followed by those who are multiracial or American Indian/Alaskan Native. We also know from community listening sessions that use of coinsurance within EHBs is generally confusing for consumers and makes costs of services impossible to predict for the

individual and family, also leading to skipped or delayed care. Overall, it is urgent that CMS adopt lower, more affordable, and predictable out-of-pocket cost limitations within the EHB framework to protect people from financial instability caused by medical costs, and stop the year to year gradual increases in allowed deductibles and out-of-pocket maximums.

Conclusion

While much of what CMS has proposed makes necessary improvements, we continue to urge CMS and HHS to revisit the challenges to innovation and value and equity-driven benefits posed by the current structure of the federal actuarial value calculator and the continually increasing out-of-pocket costs that have been allowed through ever higher deductibles and out-of-pocket maximums. We appreciate the opportunity to support CMS's efforts to improve the Notice of Benefit and Payment Parameters rules and regulations. Thank you for your consideration.

Sincerely,

Adam Fox
Deputy Director
Colorado Consumer Health Initiative
afox@cohealthinitiative.org



Illinois Primary Health Care Association

January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

We at the Illinois Primary Health Care Association (IPHCA) submit the following comments as the statewide primary health care association representing all 53 of Illinois' community health centers which serve more than 1.5 million patients across over 400 service sites in medically underserved areas annually. Our members deliver high-quality, integrated medical care, behavioral health treatment, and dental services. We are vital to the nation's safety net and offer care for many marginalized communities. Throughout the COVID-19 public health emergency and for decades preceding it, community health centers have been on the frontlines as reliable sources of health information and care.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. Roughly 60% of our patients are covered through Medicaid, 20% are uninsured, and the remaining 20% have Medicare, Marketplace coverage, or employed sponsored commercial plans.

Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. During the most recent open enrollment, Illinois experienced a 6% increase in Marketplace enrollment over the preceding year. This success was in part due to the efforts of outreach and enrollment assisters based at our statewide network of community health centers. Between August 27, 2022 and January 30, 2023, health center staff assisted in 98,328 cases and completed 16,195 total enrollments. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions.

With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, IPHCA's member federally qualified health centers (FQHCs) have helped thousands of individuals seeking coverage. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. IPHCA strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."



In fact, IPHCA was awarded a \$3.2 million grant by CMS to operate a statewide health insurance navigator program. This grant award serves as a testament to the commitment that Illinois FQHCs have made in connecting marginalized communities to affordable healthcare. The grant is a 3-year noncompetitive cycle providing 3.2 million each year. The funding has allowed IPHCA, its members, and partner organizations to employ navigators throughout Illinois. Navigators have worked on the ground in communities to assist the uninsured and other underserved patients with obtaining and utilizing health insurance coverage.]

IPHCA welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

IPHCA supports CMS' proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. IPHCA recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, IPHCA recommends CMS enforce the "any willing provider" statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs "shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically underserved individuals." As our federal counterpart, the National Association for Community Health Centers (NACHC), has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. IPHCA recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFM must "offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan's provider network for the respective QHP certification plan year, where

¹ Section 1311(c)(1)(C)

Commented [AK1]: @Paula Campbell @Carol West pulled from August 2021 press release but please feel free to update if newer info is available
<https://www.iphca.org/wp-content/uploads/2021/08/IPHCA-Awarded-CMS-Health-Navigator-Grant.pdf>

Commented [PC2R1]: I made a few minor changes

Commented [PC3R1]: The aqua highlight. The 80 million wasn't just to health centers.

Commented [PC4R1]: this links talks about the increase this year for the second year of the three year cycle.
<https://medcitynews.com/2022/08/biden-administration-distributes-nearly-100m-to-navigators-for-2023-open-enrollment-period/#~:text=For%20the%202022%20open%20enrollment,vaccination%20clinics%20and%20food%20drives>



an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, IPHCA believes that these good-faith contracts should extend to all FQHCs in their service area.

IPHCA recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. Currently, there is no official tracking mechanism for stakeholders, like IPHCA, to engage with states and hold them accountable. IPHCA recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities.

Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

IPHCA strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators,

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013.pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act>



community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. IPHCA appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. IPHCA appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

IPHCA also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

IPHCA also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew, trillion%20or%20%2412%2C530%20per%20person>.

⁶ <https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights, and%20Table%20A%2D1>.

⁷ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/>.



IPHCA appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ This investment quadrupled the number of navigators for that year. These 1,500 employees held more than 1,800 outreach and education events at locations like libraries, vaccination clinics and food drives.⁹

Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers" and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.¹⁰

IPHCA is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The Marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner.

In June 2022, IPHCA along with our partner organization the Illinois Public Health Association received a \$10 million grant for the COVID-19 Health Equity Pandemic Health Navigator Project, a program allowing community health workers to continue connecting vulnerable constituents with basic human needs and health resources. Community health workers are frontline public health champions with a close understanding of services and needs in the areas in which they serve. More than 650 Illinoisans have completed the Illinois Public Health Association's training program to become community health workers through the Pandemic Health Navigator Program. These

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

⁹ <https://medcitynews.com/2022/08/biden-administration-distributes-nearly-100m-to-navigators-for-2023-open-enrollment-period/#:~:text=For%20the%202022%20open%20enrollment,vaccination%20clinics%20and%20food%20drives.>

¹⁰ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>



individuals bolstered the State's contact tracing and community vaccination efforts. They also applied their knowledge of available resources to connect tens of thousands of Illinoisans quarantined by COVID-19 with supports for basic needs including food, medicine, and safe housing. Between March 2021 and June 2022, more than 137,000 individuals sidelined by a COVID-19 infection or exposure received assistance through the program. In most cases, those requests were fulfilled within 48 hours of their receipt.]

Before the pandemic, CHWs have long been employed by community health centers. They near peer individuals have inherent cultural and linguistic competency and are expert at outreach and engagement and also help with health education and promotion efforts.

Research has indicated that while CHWs have been shown to improve patient outcomes, particularly for racial and ethnic minorities, immigrants, and rural patients, the workforce has grown at a modest pace in large part due to chronic funding challenges.¹¹

Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹² While those were significant cuts, a cut to funding at a crucial time of redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹³ this means States will be continuing to complete these determinations into 2024.

Illinois' Medicaid rolls have grown to roughly 3.7 million in state fiscal year 2022, up from 3.1 million in fiscal year 2020.¹⁴ Kaiser Family Foundation estimates that between 5-13% decline in enrollment when continuous eligibility requirements end.¹⁵ In Illinois, this means that between 650,000 and 1,690,000 can be expected to lose coverage following the resumption of redeterminations which are set to begin April 2023.¹⁶

¹¹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8428847/>

¹² <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

¹³ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

¹⁴ <https://www2.illinois.gov/hfs/info/factsfigures/Program%20Enrollment/Pages/Statewide.aspx>

¹⁵ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

¹⁶ <https://www2.illinois.gov/hfs/SiteCollectionDocuments/HFSCoverageOpsPlanPUBEDSpecialMeeting01252023.pdf>

Commented [AK5]: @Carol West @Paula Campbell pulled from June 2022 press release but feel free to update if newer info is available https://www.iphca.org/wp-content/uploads/2022/07/PHN_press-release-new-grant_6.30.22-2.pdf

Commented [PC6R5]: This is good from the COVID perspective. Ashley is working on other perspective like asthma, diabetes..., we have a joint HRSA CHW grant as well.



These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to assist with enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, IPHCA they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. IPHCA also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{17 18 19} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

IPHCA supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,²⁰ there have been reports of people discovering they obtained Marketplace coverage without their knowledge.

For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.²¹ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

IPHCA supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product

¹⁷ Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹⁸ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁹ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

²⁰ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

²¹ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>



network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.²² While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, IPHCA applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and IPHCA also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. IPHCA appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

IPHCA also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. IPHCA appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

IPHCA recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection IPHCA supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to

²² <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>



more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. If you have any questions, please contact Cyrus Winnett, Senior Vice President of Public Policy + Governmental Affairs, at cwinnett@iphca.org.

Sincerely,

Cyrus Winnett
Senior Vice President
Public Policy + Governmental Affairs
Illinois Primary Health Care Association

COALITION FOR WHOLE HEALTH

January 30, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2024

Dear Administrator LaSure:

The Coalition for Whole Health is a broad coalition of local, State, and national organizations in the mental health and substance use disorder prevention, treatment, rehabilitation, and recovery communities. We appreciate the opportunity to comment on the proposed rule detailing standards related to benefits and payment. We thank you for your strong commitment to making mental health (MH) and substance use disorders (SUD) a top priority and for working to ensure that individuals with MH/SUD needs receive quality care.

We appreciate the Department's continued recognition of the critically important consumer-protective ACA requirements, including for people with MH/SUD. On behalf of our constituencies, we offer the following comments and recommendations in response to the proposed rule:

Network Adequacy Provisions: We appreciate the Department's continued work to strengthen care access for underserved individuals, including those with MH/SUD. The Coalition has long advocated for policy reforms that will improve meaningful access to culturally effective care. We strongly support the rule's proposals to strengthen network adequacy for MH and SUD services. Specifically:

- **Essential Community Providers (ECP):** We strongly support the Department's proposal to establish Mental Health Facilities and Substance Use Disorder Treatment Centers as two additional stand-alone ECP categories, for the 2024 plan year and subsequent plan years. We agree that it is important to have separate and distinct stand-alone categories for MH providers and SUD providers and would urge you to consider expanding those categories to include more than one MH facility and one SUD facility. We recommend a requirement that would call for the inclusion of 35% of available MH providers and 35% of available SUD providers. We appreciate the Department's specific effort to improve access to MH and SUD care given continued service and medication gaps, including disproportionately for BIPOC consumers, and escalating rates of overdose and suicide death.

The Coalition also supports the Department's proposal to require Qualified Health Plan issuers to contract with at least 35 percent of available Federally Qualified Health Centers (FQHCs) and at least 35 percent of available Family Planning Providers that qualify as an ECP in the plan's service area, in

addition to meeting the current overall 35 percent ECP threshold requirement in the plan's service area.

- Appointment Wait Time Standards: The Coalition supports the rule's proposal to begin in the 2024 plan year to ensure that QHP issuers meet minimum appointment wait time standards.

Requiring a Provider Network: The Coalition support the rule's proposal to require all ACA plans to use a network of providers that comply with the Department's network adequacy and ECP requirements.

In addition to the Network Adequacy provisions proposed in the rule, to further strengthen and grow MH/SUD network adequacy and provider reimbursement rates to improve access to care in all communities, and to come into greater compliance with the Mental Health Parity and Addiction Equity Act, we urge the Department to work with the Department of Labor to:

- Adopt parity-compliant quantitative network adequacy standards for a wide range of MH and SUD providers in public and private insurance, respectively, to improve access to affordable treatment and identify the cause of network gaps. These standards should include, at a minimum: metrics on appointment wait time, travel distance, and provider-to-enrollee ratios, and the inclusion of essential community providers in networks.
- Continually monitor compliance with network adequacy standards and utilize a number of different compliance tools, including market conduct surveys; collecting and analyzing data on out-of-network claims, MH and SUD provider availability, and reimbursement rates; and consumer surveys and complaints. They should require carriers to explain any disparities and demonstrate that such disparities do not violate the Parity Act.
- Require greater transparency about network design, reimbursement rate setting standards, and compliance with network adequacy requirements, which should be publicly available in plain language to inform consumers.
- Ensure consumers continue to have a choice in the service delivery model through which they receive their care by precluding plans from using telehealth appointments to satisfy network adequacy requirements unless the telehealth service is available, accessible, clinically appropriate, and the consumer elects to receive the service by telehealth.

Provisions on Standardized Plan Options: The Coalition has long supported the Department's work to establish standardized plan options for consumers. We support the rule's proposal to continue HealthCare.gov's Easy Pricing plans. We also support the rule's proposal to require that issuers place all covered drugs in the appropriate cost-sharing tier unless there is an "appropriate and non-discriminatory basis" for placing the drug in the specialty tier. This can be a particular problem for MH and SUD medications.

The Coalition also supports the rule's proposals to limit non-standard plan options and to ensure consumers have accurate plan information. We share the Department's concerns that many plan options create confusion and frustration for consumers seeking to enroll in coverage. We support the Department's proposal to limit the number of non-standardized plans that issuers can offer through the federal marketplace/state marketplaces that use the federal platform. The Coalition also supports the Department's proposal to require that marketing names for QHPs include correct information and do not include content that is misleading. The Coalition would support the Department requiring a specific format for use by all QHPs.

Navigators and Other Consumer Assistance Provisions: The Coalition supports the rule's proposal to rescind the prohibition on door-to-door navigation assistance. We appreciate the Department maintaining certain consumer privacy protections while increasing access to consumers with mobility and other travel limitations.

The Coalition also supports the rule's proposal to require agents and brokers to document that the consumer has reviewed and confirmed their application information before they submit an application.

Additional Consumer Protections: The Coalition supports the rule's proposal to put into regulation the requirement that issuers covering dependent children do so until the end of the plan year during which the young person turns 26. This will increase clarity for enrollees and QHP issuers.

In addition, the Coalition supports the Department's proposal to establish a timeliness standard for notices issuers send plan enrollees when they have missed premium payments.

We thank you again for the opportunity to provide comments on the proposed 2024 benefit and payment parameters rule. We strongly support the goals of the ACA to ensure that all Americans have access to high-quality, affordable health care, including comprehensive care for MH and SUD conditions. Please contact Gabrielle de la Guéronnière (gdelagueronniere@lac-dc.org) if you have any questions or if we can be of further assistance.

The Coalition for Whole Health



January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

Thank you for the opportunity to provide comments on the notice of benefit and payment parameters for 2024. The Wright Center for Community Health (TWCCCH) is a Federally Qualified Health Center (FQHC) Look-Alike, an Essential Community Provider of safety-net primary health services, an Opioid Use Disorder Center of Excellence, and a Ryan White HIV/AIDS provider. TWCCCH currently serves over 40,000 unique patients, operating nine primary care community health centers throughout Northeastern Pennsylvania, inclusive of a mobile medical and dental unit. TWCCCH is affiliated with TWCGME, and serves as the cornerstone ambulatory whole person care delivery service organizational member of our Teaching Health Center Graduate Medical Education Safety-Net Consortium (THC GME-SNC). Together with GME-SNC stakeholders, TWCCCH and TWCGME train primary care residents and fellows in a community-based, needs-responsive, interprofessional workforce development model to advance our shared mission to improve the health and welfare of our communities through inclusive and responsive health services and the sustainable renewal of an inspired, competent workforce that is privileged to serve. Our perspective is informed by our holistic approach to community-oriented primary care and graduate medical education.

At TWCCCH, 32 percent of our patients are insured by Medicaid, 18 percent are insured by Medicare, 6 percent are dually eligible, and 3 percent are uninsured. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace. It also includes assisting individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. TWCCCH strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration's proposed changes in the proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes." The following comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers, II. Reducing Barriers to Enrollment and Financial Assistance, III. Cuts to User Fees, and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

To ensure that insurers are contracting with FQHCs and FQHC Look-Alikes (Look-Alikes), TWCCCH recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically-underserved individuals.” As TWCCCH has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. TWCCCH recommends CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”^[2] but given the crucial role health centers play in delivering primary care services, TWCCCH believes that these good-faith contracts should extend to all FQHCs in their service area.

In the alternative, TWCCCH supports CMS’s proposal at § 156.235 to increase the percentage of FQHCs and Look-Alikes that Qualified Health Plan (QHP) issuers are required to contract with from 30% to 35%. FQHCs and Look-Alikes make up the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)^[1] to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. TWCCCH recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and community health centers, in their service area.

TWCCCH recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs and Look-Alikes are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate^[3] unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs/Look-Alikes and their patients, as well as to health centers’ continued financial viability. Currently, there is no transparent, visible, official tracking mechanism for stakeholders like TWCCCH to engage with states and hold them accountable. TWCCCH recommends CMS create a tracking system to ensure FQHCs and Look-Alikes are being reimbursed properly by the QHPs or managed care plans with which they contract.

Notably, ECPs are also “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”^[4] part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how ECPs, like FQHCs and Look-Alikes, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities with services such as dental care, behavioral health, specialty care, translation services, food pantries, and housing support. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, to understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

Reducing Barriers to Enrollment and Financial Assistance

TWCCH strongly supports the proposed changes—repealing §155.210(d)(8) and §155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers, such as TWCCH, employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. TWCCH appreciates the Administration’s continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee’s residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person services. Barriers such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural areas where it can be difficult to solicit enrollment assistance. TWCCH appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

TWCCH also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.^[5] With the median U.S. household income reported at \$70,784 in 2021,^[6] that is a large

percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due to being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

TWCCH appreciates CMS's proposal under §155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.^[7] This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

Cuts to User Fees

TWCCH appreciates the Administration's continued investment in the outreach and enrollment (O/E) workforce.^[8] **However, TWCCH is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers.** The Marketplace User Fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have deployed creative solutions to support O/E. For instance, CHW has incorporated Community Health Workers (CHWs) into our patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. Given that these core marketplace functions are funded by user fees, CMS's proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.^[10] While those were significant cuts, a cut to funding at a crucial time of

redeterminations may negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;^[11] this means States will be continuing to complete these determinations into 2024. These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the User Fee, TWCCCH suggests they remain at their current percentages: 2.5% in the Marketplace 2.25% in the state-based Marketplace. TWCCCH also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much on user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{[12] [13] [14]} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

Increasing Health Insurance Enrollee Protections

TWCCCH supports CMS's proposal to amend §155.220(j)(2)(ii) to require web brokers to submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment applications have been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers sign enrollees up for different coverage than promised or without their consent,^[15] there have been reports of people discovering they obtained Marketplace coverage without their knowledge. For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.^[16] While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

TWCCCH supports the first CMS proposal in §156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average Marketplace consumer has grown from 25.9 to 113.6 in 2023.^[17] While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, TWCCCH supports CMS's proposal to revise §156.201 to require insurers to place covered drugs in the appropriate formulary tier, and TWCCCH also agrees that four tiers in a plan's drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. TWCCCH appreciates CMS's intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers. Furthermore, we urge CMS to consider further opportunities to promote prescription drug pricing parity across different pharmacies.

TWCCCH also supports §156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure consumers' continuity of coverage and assure access to health care services. Administrative functions can impact continuity of coverage, and TWCCCH supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

TWCCCH recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection TWCCCH supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly

appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Laura Spadaro, Vice President of Primary Care and Public Health Policy at spadarol@thewrightcenter.org.

Sincerely,



Laura Spadaro
VP, Primary Care & Public Health Policy
The Wright Center for Community Health
The Wright Center for Graduate Medical Education
spadarol@thewrightcenter.org
Mobile: (570) 468-7919

[1] Section 1311(c)(1)(C)

[2] <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

[3] Section 1902(bb) of the Social Security Act

[4]

<https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

[5]

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew, trillion%20or%20%24%2C530%20per%20person.>

[6] [https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1\).](https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1).)

[7] [https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.](https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/)

[8]

<https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

[9] <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

[10] <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

[11] [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

[12] Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

[13] McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

[14] Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

[15] <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

[16] <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

[17] <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

PUBLIC SUBMISSION

As of: 1/31/23, 1:30 PM
Received: January 30, 2023
Status: Posted
Posted: January 31, 2023
Category: Individual
Tracking No. ldj-kjcc-6ukh
Comments Due: February 13, 2023
Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0264

Comment on CMS-2022-0192-0003

Submitter Information

Email: llewis@invobh.com

Organization: InvoBH

General Comment

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 And “HHS Notice of Benefit and Payment Parameters for 2024 Proposed Rule”

“CMS also proposes to require agents, brokers, and web-brokers to document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer prior to application submission”

“In addition, CMS proposes to require agents, brokers, or web-brokers to document the receipt of consent from the consumers they are assisting. This proposal would help with enforcement and help resolve disputes between enrolling entities and consumers, or between multiple enrolling entities”

Our Agency opposes implementation of CMS 10840 Form,
Because of the following reasons, e.g.

1. Our current professional practice is well regulated by each State where we are licensed to practice, plus annual additional States and Federal annual FFM and Certifications passing requirement, CE requirements with Licensing renewal, speaking at 6-years recipient of Circle of Champions for helping Marketplace clients without and with compensation;
2. Our Current Healthcare Systems are extremely complex, putting more restrictions to licensed Professionals, will further diversify our time to focus in assisting consumers with serious healthcare planning and investment conversations, where their decisions today can impact their livelihood; because getting access for Affordable Care and Get Affordable Health Insurance, are 2 different concepts, where currently only 1 message has been communicated publicly that Affordable Healthcare is only \$0 or \$10. The fact is there are NO \$0 or \$10 health plans, rather subsidized by our income taxes.
3. While 1 in 4 Americans have a Medical Debt of \$88 billion dollars, and many delay in seeking care -

this fact is an example of those health plans that are NOT “Affordable” to these Americans. This situation is an indication that these consumers did not receive a licensed professional advice

4. Healthcare Planning is a personal experience, based on each individual’s health care needs even within the same family, it is a lifetime financial planning journey, requires careful consideration, when making investment decisions for self and the family s/he support, hence we strongly believe that only licensed and certified agents and brokers are qualified to offer such professional advice, because we bear fiduciary responsibility to every consumer we serve, under our licensee and contractual agreements. It is not a simple \$0 or \$10 “Cheap” online or in-person shopping experience.

5. While we are serving our clients during the year, our primary tasks have always been Education, e.g. premium Payment Scheduling and Important of Payment on Time to assure coverage becoming effective, Medical billing and claim Questions, we don’t see AOR/BOR (agent/Broker of record) as the prime reason presented, nor do we concur the Form 10840 Supporting document with its underestimated impacts, and it will further distract agents/brokers time to service our current clients with really issues in understanding the health plan's benefits and finding affordable care, and reading a medical bill and reducing medical debts

6. Given the learning experiences, from Marketplace and Medicare Enrollment Processes, e.g. we can see many other ways to streamline and improve the current enrollment process, such as using a unique Healthcare ID number (HID) like Medicare ID (MID), standards of operation (SOPs), using a broker priority email supporting system instead of only Phone Support Systems can benefit agent/broker more effectively, where marketplace can adopt and implement “medicare enrollment system” with no need to “reinvent the wheel”, putting further delays to current enrollment process?

7. Re Regs and Compliance Standards, are Navigators, SHIP, Claim, 340B organizations, Social Security Office, Community Clinics and Medicaid Office subjected to the same standards? If not, what are the reasons for their exemptions?

8. We have questions regarding the ways that health. Gov has been promoting “Affordable Health Plan” by Price through Facebook, Email, SMS and voice to the clients we have already served? Such messages have been undermining our professional service and caused further confusion to our clients?

9. As always, we are looking forward to the open dialogs with CMS, because our National Health Expenditure (NHE) has reached \$4.3 trillion dollar (18.3% GDP per 2021 data). When we are having “Affordable” healthcare planning conversations, we need to be clearly defining “Affordability” with 1 voice to avoid any confusion by taking a holistic approach in moving healthcare policies forward.

Ref: 2022-27206 CMS Comment Period related to:

CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Dear Secretary Becerra, Administrator Brooks-LaSure, Deputy Director, Dr. Montz, and the entire staff involved with research and development of this proposal,

We are writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. We appreciate the opportunity to provide comments on this important proposed rule. For context, and full disclosure, our organization is:

Price Services Group, L.L.C., a healthcare brokerage focused on helping individuals navigate the health insurance market. Our expertise in the individual health market allows us to work directly with customers across 11 total states spanning numerous and SBM Markets and the FFM.

We have three core missions within the financial side of healthcare: 1) working one-on-one with consumers to help them efficiently navigate the system, 2) working with trade groups such as NABIP to indirectly help the broader market and advise on consumer needs, and 3) working with Congress and government agencies to report inadequacies, inequities, and consumer catastrophic claims that need policy changes to stop dangerous recurring events.

We have carefully reviewed the proposed rule and have comments to offer regarding the following topics.

- No Binder Payment – Zero Premium Remapping
- Section 153(2)(A) Market Adjustment
- Section 155.106 State Waiver Timelines
- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community
- Section 155.305 Failure to Reconcile Extension
- Section 155.315/155.320 Income Attestations

- Section 155.335 Annual Mapping
- Section 155.420 Mid Month SEP
- Section 155.420(d) Provider Network Change SEP

Thank you for considering our comments. We hope that our input will be helpful in the development of the final rule.

Sincerely,

Kayla Price

No Binder Payment – Zero Premium Remapping

The first topic we would like to cover is the proposal to move consumers to a zero-premium plan in the event the consumer enrolls in a qualified health plan during open enrollment, but fails to pay their premium.

We would like to express our concerns about the proposal to automatically move consumers who do not pay their binder payment by the deadline to a zero-premium plan. While we recognize that the zero premium plan may be more affordable for some consumers and provide a safety net for those at risk of losing coverage, there are also several potential drawbacks to this proposal.

One concern is that the automatic switch to a zero premium plan could be confusing and disruptive for consumers, who may not have been expecting to be enrolled in a different plan. The new plan may not offer the same coverage or provider network as the original plan, which could cause difficulties for consumers who are already receiving care or have established relationships with certain providers.

Additionally, consumers may not have a choice in whether to switch to the zero-premium plan, even if they prefer their original plan or are able to pay their binder payment at a later date. This could limit their ability to make informed decisions about their healthcare coverage.

Finally, in previous years, we have noted that the accuracy and timeliness of outstanding premiums have not always been accurate. Consumers may make a binder payment, but if the data isn't shared from the carrier to the marketplace either accurately, or by the deadline, the consumer may be mapped to another plan causing further confusion.

Overall, while we recognize the potential benefits of the zero-premium plan, we believe that it is important to carefully consider the potential drawbacks and ensure that consumers have the ability to make informed decisions about their healthcare coverage.

Section 153(2)(A) Market Adjustment

Next, we would like to comment on the options for determining the market basket update as outlined in section 153(2)(A) of the Affordable Care Act. As you are aware, the COVID-19 pandemic has had a significant impact on healthcare costs, with spending increasing by over 10% in 2020 according to a

recent study published in Health Affairs (<https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.01397>). Considering this, we believe it is important to consider options that take into account the unusual circumstances of 2020, consider smoothing over both this coming plan year and future years, and ensure that payment rates accurately reflect the current market conditions for healthcare services.

Based on your recommended options, and the Health Affairs study, we believe it will be prudent to use data from 2017-2020 in order to spread out the assumption of the increase in costs over a longer time period. This would also hold true for the next NBPP that will account for the 10% spike in 2020, but also the lower-than-average spending reflected in 2021 numbers. It may be prudent to adjust 2017 numbers due to inflation to reflect spending more accurately.

We appreciate the difficult task of determining payment rates in the face of unprecedented challenges, and we hope that these suggestions may be helpful in your considerations. Thank you for your attention to this important matter.

Section 155.106 State Waiver Timelines

Next, we would like to express our concern about the current timeline for states to transition to the ACA marketplace. As outlined in section 155.106, states are required to have 3-14 months (depending on type of waiver) from the time CMS greenlights their transition to when their system can be live for open enrollment. We believe that this timeline is insufficient and that CMS should have more time to properly prepare for this transition. We are licensed and anticipate participation in the MD and VA (currently) markets as they transitioned away from FFM, and states need more ramp up time to iron out kinks.

There are several reasons why we believe that CMS and states should have more time to transition to their SBM marketplace. First and foremost, this will help individuals to have more time to prepare for this transition. Many individuals rely on the ACA marketplace for their healthcare coverage, and a rushed transition could lead to confusion and uncertainty for these individuals. By giving states more time to transition to the SBM marketplace, individuals will have the opportunity to better understand what the shift means. We routinely met consumers who believed that the plans were different because they couldn't get healthcare.gov coverage anymore.

Additionally, more time for the transition will benefit insurers and enrollers as well. Insurers and enrollers need time to prepare for the transition to the state's marketplace, including updating their systems and processes to comply with the new requirements. A core tenant of the SBM waiver is for states to show how their unique approach to the market would save federal funds. This "unique" autonomy adds additional considerations for insurers and enrollers as state level rule making varies from FFM rules. A rushed transition could lead to delays and difficulties for these stakeholders, which could ultimately impact the quality of care and coverage that individuals receive. By giving states more time to transition to the SBM marketplace, insurers and enrollers will have the opportunity to properly prepare and ensure that they are able to provide high-quality care and coverage to individuals.

In conclusion, we strongly believe that CMS and states should take more time to transition to SBM marketplaces. This will help individuals, insurers, and enrollers to have more time to prepare for this transition and ensure that the marketplace is able to function effectively and efficiently. We encourage CMS to consider extending the timeline for the transition to the State marketplaces to allow for a smoother and more successful transition.

Section 155.210(d)(8) Navigator Marketing

Next, we want to express our concerns about the potential impact of removing subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

We believe that removing this provision could have several potential negative consequences.

Allowing navigators to conduct door-to-door enrollment activities could raise concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from enrollment assistance staff. It could also lead to confusion or misunderstandings about the nature of the assistance being offered, as some consumers may not be aware that navigators are trained and certified by the Department of Health and Human Services (HHS) to provide assistance. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.

Similar to the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.

Lastly, we feel very strongly that both Navigators and Brokers have a separate and distinct role within the health insurance market for individuals. Consumers above 150% of the Federal Poverty Limits, especially those with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not brokers, you are keep a better qualified resource, the broker from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

We urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220(j) Requirements of the Agent/Broker Community

Providing Correct Information to the FFs (Section 155.220 (j))

I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance. As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month. This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers. I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS and large call centers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain. Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years. I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.

Section 155.220 (j)(2)

I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule. Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair. I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information

Section 155.220(j)(2)(ii)

I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers. The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information. The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc. The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided. If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry. I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation. I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

Section 155.220(j)(2)(ii)(A)

I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community. I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market. An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information.

Section 155.220(j)(2)(ii)(A)(1)

To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct. I am concerned with the words, "under penalty of perjury." I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity. I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed. Please keep in mind, many consumers do not have access to computers, most have access to phones. With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.

Section 155.220(j)(2)(ii)(B)

This section is speaking about an issue that is happening across the nation to many professionals. I know colleagues who have had a "rouge" agent steal their clients. Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system. This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your

agent, they will answer yes or no. Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished. When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent? Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again. We need help in this area but requiring additional paperwork is not the answer.

Section 155.305 Failure to Reconcile Extension

Next, we'd like to express our thoughts on the potential change to Section 155.305 of the ACA, which currently requires exchanges to remove premium tax credits (PTCs) if the IRS determines that an individual did not reconcile their PTCs for the previous year.

One potential pro of changing the rule to a two-year period is that it could give individuals more time to reconcile their PTCs and avoid having to pay back any excess credits. This could be particularly beneficial for individuals who have complex financial situations or who have difficulty navigating the process of reconciling their PTCs. In addition, such a change could help to prevent situations where individuals have filed an extension with the IRS in April and have not yet filed their return by the time the IRS reviews PTCs, resulting in the exchange removing PTCs even though the individual's tax situation may ultimately be found to be in compliance.

However, we also recognize that there are potential cons to changing the rule to a two-year period. One concern is that a two-year reconciliation period could lead to more instances of fraud or abuse, as individuals may be able to receive excess credits for a longer period of time before they are detected and required to pay them back.

One further consideration is that for individuals who exceed 400% of the federal poverty limit, the amount of PTCs they could be subject to pay back could be much higher than for lower income households, and a two-year reconciliation period could result in a higher repayment effect for these individuals.

In conclusion, we believe that the decision to change the rule from a one-year to a two-year period should be carefully evaluated, taking into account the balance of the potential pros and cons as well as the specific circumstances and needs of the individuals and small businesses participating in the exchanges.

Section 155.315/155.320 Income Attestations

Next, we'd like to provide comments on the use of attestation in the ACA Health Insurance Marketplace to address income inconsistencies. Section 155.315 and 155.320 of the Affordable Care Act (ACA) relate to income inconsistencies when an individual is applying for coverage through the exchange. These provisions require that the exchange verify an individual's income in order to determine their eligibility for premium tax credits and other cost-sharing reductions.

One option for addressing income inconsistencies is for the exchange to accept an attestation from the consumer, in which they affirm that their projected income for the coming year will be different from their prior year income. While this approach has the potential to be more streamlined and efficient, and may be more convenient for the consumer, there is a risk that the consumer's attestation may not accurately reflect their actual income for the coming year. Additionally, if the exchange relies solely on an

attestation and does not verify the consumer's projected income, it may be more vulnerable to fraud or abuse.

In North Carolina, the current process for addressing income inconsistencies involves requiring the consumer to submit their taxes, two additional documents, and undergo an outbound call from the state before an attestation can be accepted. While this process may be more thorough in terms of verifying income, it may also be more burdensome for consumers compared to simply accepting an attestation without these additional requirements. There are a few ways in which accepting an attestation may reduce the burden on consumers compared to the current process in North Carolina: it may reduce the amount of paperwork that consumers need to complete, reduce the risk of transmitted documents being at risk of cyber security events, allow for a quicker resolution of income inconsistencies, and be more convenient for consumers.

Overall, it may be necessary to balance the convenience and efficiency of accepting an attestation with the need to ensure accuracy and prevent fraud. In states, like Maryland, we have seen an attestation with a space to explain why prior electronic data of income, and prior tax documents may not reflect upcoming income. This would strike a balance between the risk and reward as consumers will not only attest to their projected MAGI, but offer an explanation as to WHY it is changing. Events like having a child, retirement, self employed income swings, and many other life events routinely cause MAGI changes that can be explained within the attestation.

Section 155.335 Annual Mapping

Section 155.335 of the Affordable Care Act (ACA) relates to the annual process of redetermination, which involves reviewing an individual's eligibility for premium tax credits and cost-sharing reductions (CSR) and determining the appropriate level of assistance. This provision currently requires the exchange to map individuals to different plans based on their income and household size, as well as other factors such as their tobacco use and any special enrollment circumstances.

If CMS were to change this provision to include network IDs, net premium, maximum out-of-pocket (MOOP), and CSR in the mapping process, it could have some potential pros and cons:

Pros:

Adding these factors to the mapping process could provide a more comprehensive and accurate assessment of an individual's needs and preferences. Network IDs, for example, could be helpful in determining whether a particular plan is a good fit for an individual based on their access to preferred providers.

Including net premium and MOOP in the mapping process could help ensure that individuals are enrolled in a plan that is affordable and meets their financial needs.

Incorporating CSR in the mapping process could help ensure that individuals receive the appropriate level of assistance based on their income and other factors.

Cons:

Adding more factors to the mapping process could make it more complex and time-consuming for the exchange to develop multiple use cases to find the appropriate plan for an individual. This could lead to delays in the redetermination process.

It could also be more challenging for individuals to understand and navigate the mapping process if there are more factors to consider and it isn't clear from the prior plan to the new plan, which variables are the most prudent.

There may be additional administrative and logistical challenges involved in implementing these changes, which could impact the overall efficiency and effectiveness of the redetermination process.

Additional consideration of Gold plans vs CSR73:

As for the idea of considering a map to a gold plan when someone has CSR73 if the premium is cheaper, this could potentially be a good idea in some cases. Gold plans generally have higher premiums than other metal levels, but they also typically offer lower out-of-pocket costs and more comprehensive coverage. If the premium for a gold plan is cheaper than the premium for a plan with CSR73, it may be worth considering for an individual who is eligible for CSR73. However, it's important to keep in mind that there are other factors that may also be relevant, such as the individual's access to preferred providers, their financial needs and preferences, and their overall health status. It may be helpful for the individual to carefully compare the costs and benefits of different plan options to determine which one is the best fit for their needs.

Section 155.420 Mid Month SEP

Section 155.420 of the Affordable Care Act (ACA) relates to special enrollment periods (SEPs), which allow individuals and families to enroll in a health insurance plan outside of the annual open enrollment period. According to this provision, the start date for an SEP is typically the month following the event or enrollment, whichever is later. This means that if an individual experiences a qualifying event (such as a change in employment status or a move to a new area) that allows them to enroll in a new plan through an SEP, their coverage will typically begin the month after the event or their enrollment date, whichever is later.

Allowing the start date for an SEP to be whichever is earlier (rather than whichever is later) could potentially have some pros and cons:

Pros:

Allowing consumers to enroll on the first of the month that has a loss of coverage mid month could allow them to get coverage sooner in some cases. For example, if an individual experiences a qualifying event in the middle of the month and enrolls in a new plan through an SEP, their coverage would typically start the following month under the current rules. Removing this requirement could allow their coverage to start earlier, potentially reducing any gap in coverage.

This change could also help ensure that individuals have access to timely and continuous coverage, which is important for their overall health and well-being.

Cons:

Making this change, however, could result in individuals enrolling in a new plan earlier than they intended or were aware of. For example, if an individual experiences a qualifying event and enrolls in a new plan through an SEP, but does not realize that their coverage will start immediately, they may end up paying premiums for coverage they do not need.

This change could also potentially result in confusion or misunderstandings about when coverage will begin, which could lead to issues with billing and payment.

Allowing the start date for an SEP to be whichever is earlier could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

Overall, it's important to carefully consider the potential pros and cons of allowing the start date for an SEP to be whichever is earlier before making any changes to this provision. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

Section 155.420(d) SEP for Network Changes

The Centers for Medicare and Medicaid Services (CMS) is proposing a change to section 155.420(d) of the Affordable Care Act (ACA) that would create a special enrollment period (SEP) for individuals who are enrolled in a qualified health plan (QHP) and whose provider is no longer in network during the plan year.

This change could potentially have some pros and cons:

Pros:

Creating an SEP in this situation could allow individuals to enroll in a new QHP that includes their provider in its network, which could be important for maintaining access to care. This could be particularly beneficial for individuals who have ongoing medical conditions or needs that require ongoing treatment from a specific provider.

An SEP could provide a more flexible and responsive solution to changes in provider networks, as it allows individuals to enroll in a new plan if their provider is no longer in network.

Cons:

Creating an SEP could potentially lead to disruptions in coverage and additional administrative burden for individuals, as they would need to enroll in a new plan and potentially switch to a new provider. This could also be disruptive for providers, as they may need to transfer medical records and establish a new care relationship with the individual.

An SEP could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

One alternative approach to addressing provider network changes could be to require the provider to accept in-network rates through the end of the plan year. This approach could have some pros and cons as well:

Pros:

Requiring the provider to accept in-network rates through the end of the plan year could help ensure that individuals have continuous access to care without the need to switch providers or enroll in a new plan.

This approach could also reduce administrative burden for individuals and providers, as it would not involve enrolling in a new plan or transferring medical records.

Cons:

Requiring the provider to accept in-network rates may not be feasible in all cases, depending on the terms of the provider's contract with the insurer.

This approach could potentially result in financial implications for the provider, as they may not receive their usual reimbursement rate for the services they provide.

It could also have financial implications for the insurer, as they may need to pay higher rates to the provider in order to ensure that individuals have access to care.

Another Alternative Approach is requiring provider and insurer contracts to run on a calendar year basis and finalized before the plan year open enrollment period. This, also, could potentially have some pros and cons:

Pros:

Having provider and insurer contracts run on a calendar year basis could potentially provide more stability and predictability for individuals, as their coverage would be aligned with the calendar year. This could make it easier for individuals to understand and plan for their healthcare needs and expenses.

A calendar year basis could also provide more clarity and consistency for providers, as their contracts would be aligned with the same timeframe. This could potentially reduce administrative burden and make it easier for some providers to plan for their practice.

Aligning provider and insurer contracts with the calendar year could also potentially make it easier to track and report on healthcare utilization and costs, as there would be a clear and consistent timeframe for these metrics.

Cons:

Requiring provider and insurer contracts to run on a calendar year basis could potentially result in disruptions or gaps in coverage for individuals if they experience a qualifying event that would normally trigger an SEP. For example, if an individual experiences a change in employment status or a move to a new area during the middle of the year, they may not be able to enroll in a new plan with their care team until the following year.

This approach could also potentially create financial challenges for providers, as their contracts would be limited to a calendar year timeframe. This could make it difficult for some providers to plan for their practice and manage their financial resources.

It could also have financial implications for insurers, as they may need to adjust their rates and premiums to align with a calendar year basis.

Overall, it's important to carefully consider the potential pros and cons of requiring provider and insurer contracts to run on a calendar year basis before making any changes. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

Thank you for taking the time to consider our comments on the proposed payment parameters rule. We appreciate the opportunity to provide input on this important issue. If you have any further

questions or would like to discuss our comments in more detail, please don't hesitate to reach out to us. We would be happy to provide any additional information or clarification as needed. Thank you again for considering our perspective and we hope that our comments will be helpful in the development of the final rule.



January 30, 2023

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9906-P, P.O. Box 8016
Baltimore, MD 21244-8016.

RE: Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Dear Administrator Brooks-LaSure:

The National Immigration Law Center (NILC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule - Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

NILC is dedicated to defending and advancing the rights and opportunities of low-income immigrants and their families. We conduct policy analysis, advocacy, and impact litigation, and provide training, publications, and technical assistance to support a broad range of groups throughout the country. NILC has long been engaged in working to expand and defend immigrants' access to affordable, quality health care through our collaboration with community organizations, our analysis of federal policies and our leadership in building coalitions. Our comments focus on highlighting the elements of the proposed rule that will improve the health of immigrants while urging the Department of Health and Human Services (HHS) to go further.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

We support the proposal to allow enrollment assisters, including navigators and certified application counselors, to provide enrollment assistance through unsolicited direct contact, including door-to-door outreach. Assisters may need to use such affirmative approaches to reach immigrants who have concerns about enrolling in coverage, such as fears that enrollment could have a negative effect on their immigration status, because many of these individuals are reluctant to seek out for enrollment assistance. In addition, low-income individuals may be missed by technology-based outreach because they are less likely than the more affluent to own cell phones.¹

Should HHS adopt this provision, in assister trainings, we encourage the agency to include modules on how to approach affirmative in-person outreach in a culturally competent and respectful manner. We also further encourage HHS to focus on prioritizing Navigator funding for community-based organizations that can demonstrate existing trusted relationships within hard-to-reach communities. For example, HHS could award additional points to applicants whose relationships can be demonstrated through letters of support from community-serving institutions such as community health centers and schools.

Essential Community Providers (§ 156.235)

¹ "Mobile Fact Sheet," Pew Research Center, April 7, 2021, <https://www.pewresearch.org/internet/fact-sheet/mobile/>

We support strengthening Essential Community Provider (ECP) standards for Qualified Health Plans' (QHP) networks. ECPs like Federally Qualified Health Centers (FQHCs) are a particularly important source of care for immigrant communities. Many immigrants live in mixed-immigration status families, with some members eligible for ACA coverage and others ineligible for federal programs. By serving patients regardless of their immigration and insurance status, many ECPs often enable all members of families receive care in the same place. We support the proposal to require QHPs to contract with 35 percent of FQHCs within their service area and encourage HHS to increase this percent in future years, especially given some ECPs may serve unique communities, such as health centers that focus on Asian Americans. We also encourage CMS to develop a continuously updated list of ECPs for plans to reference when developing their networks to simplify the process of identifying and contracting with these important providers.

Providing Correct Information to the FFEs (§ 155.220(j))

We also support the proposal to require brokers and agents to affirm that applicants have reviewed the accuracy of their application prior to submission. This review will reduce the chances that unscrupulous brokers will feel emboldened to inflate applicants' income above the Medicaid eligibility level to obtain a fee or commission for enrolling them in private coverage or market themselves as being able to obtain lower premiums, obtained by falsely reducing income. This risk is significant in communities and language groups served by a small number of brokers. Reports indicate that such fraud is taking place, as well as a related abuse in which brokers underreport clients' income to inflate the premium tax credits they receive, requiring consumers to repay excess subsidies when filing their taxes.

Applicants with low reading literacy or limited English proficiency are particularly vulnerable to broker abuse but may not be able to read the application to verify its authenticity. To serve those consumers, CMS should identify alternative methods to for applicants to complete the proposed affirmation. For example, CMS may identify key pieces of information, such as income, family size, immigration status and other important information on the application, that the broker must verbally review with the applicant. CMS could also require that brokers serving patients who cannot verify the application themselves have an independent third party do so. In the longer term, providing applications in languages beyond English and Spanish is important for ensuring applicants have fully reviewed and approved their information.

CMS should incorporate into the affirmation the consumer's acknowledgement that they have received their log-in credentials for whichever enrollment portal is being used. We have heard reports that brokers and agents withhold username and password information from applicants, forcing them to return to the broker instead of exploring other enrollment resources.

Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

We support the proposal to accept an applicant's attestation of projected income where the IRS confirms there is no available tax data. This approach will simplify the enrollment process and reduce burdens on individuals with incomes below the tax filing threshold and other low-income applicants. Data Matching Inconsistencies (DMIs) continue to be a major source of lack of effectuated enrollment for immigrants because they are not provided in non-English languages, so we support all opportunities to reduce them. IRS may lack data for many immigrants who were not required to file a tax return either because they are new to the country or because they earn less than the filing threshold. This circumstance may particularly impact low-income individuals who are ineligible for Medicaid because of their immigration status but eligible for ACA enrollment. The proposal may also benefit immigrant tax filers whose income cannot be

verified through the federal data services hub because of name mismatches due to paperwork errors when they were granted status.

We also support the proposal to give all enrollees a 60-day extension for resolving DMIs when they exhaust the initial 90 days. Many immigrants work in seasonal jobs, the informal economy, or small businesses. Many immigrant households can benefit from extra time to document their projected income for all household members. For someone balancing work and family obligations, providing this documentation is burdensome. Many people, particularly those who are limited English proficient, also require multiple visits to enrollment assisters as they attempt to provide correct and complete documentation. Implementing a universal exemption will be more equitable than requiring case by case extensions, which place additional burdens on both applicants and their assisters.

While the resolving DMIs has become simpler thanks to process improvements that allow for more rapid uploading and processing of verification, they continue to represent an equity concern. They also result in increased burden for Navigators and Assisters who report spending hours with clients working to resolve them, often through multiple visits. We encourage CMS to consider additional ways to reduce the number of DMIs, to reduce the steps required by consumers to resolve them, and to provide them in multiple languages.

FFE and SBE-FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

We oppose the proposal to reduce the Federally Facilitated Exchange (FFE) user fee from 2.75 percent to 2.5 percent. We encourage HHS to retain or increase the current fee and devote additional resources to outreach and enrollment. As compared to other HHS funding sources that depend on frequently stagnant appropriations, FFE user fees permit greater flexibility in the programs they support. Data show that half of the millions of people who remain uninsured may be eligible for ACA or Medicaid coverage.² While we appreciate HHS's increase in Navigator funding over the past two years, community-based organizations continue to report the need for more resources, particularly to support the one-on-one efforts needed to enroll immigrant families with complex eligibility scenarios. We encourage HHS to keep the current user fee rate and use the continued funds to conduct an expanded enrollment campaign aimed at hard-to-reach populations.

Thank you for the opportunity to comment on these important issues. If you have further questions, please contact Ben D'Avanzo (davanzo@nilc.org).

² Gunja, Munira and Sara Collins, "Who Are the Remaining Uninsured, and Why Do They Lack Coverage?," Commonwealth Fund, August 28, 2019, <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage>

Brazos Valley Community Action Agency dba HealthPoint
1500 University Drive E
College Station, TX 77840
(979) 846-1100

January 30, 2023

Administrator, Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

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

BOILERPLATE INFO ABOUT YOUR HEALTH CENTER

HealthPoint is a non-profit community health center and Federally Qualified Health Center (FQHC) overseen by a community board of directors. As a Federally Qualified Health Center (FQHC), HealthPoint receives funds from the Health Resources & Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. HealthPoint meets a stringent set of requirements, which includes providing services regardless of a patient's ability to pay, charging for services on a sliding fee scale, and operating under a governing board that includes patients. HealthPoint is also recognized as a patient-centered medical home (PCMH). Being PCMH recognized means that HealthPoint strives to put patients at the center of their care. HealthPoint clinics receive funding from the U.S. Department of Health & Human Services and have FTCA (Federal Tort Claims Act)-deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals.

Health centers serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans who are eligible for reduced-cost coverage through Federal and State marketplaces. [PERCENTAGE OF YOUR PATIENTS THAT HAVE PRIVATE COVERAGE AND PERCENTAGE THAT HAVE MEDICAID COVERAGE] In 2021, 15% of HealthPoint patients were privately insured and 28% had Medicaid coverage. In 2022, 19% of HealthPoint patients were privately insured and 31% had Medicaid coverage. These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a key source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, **HealthPoint** FQHCs helped nearly 46,135 individuals seeking coverage in 2021. This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the Marketplace; it also includes assisting

individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance. **HealthPoint** strongly appreciates that many of these proposed changes, especially related to outreach and enrollment and Marketplace protections, build upon the Administration’s proposed changes in the proposed rule “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes.”

HealthPoint welcomes the opportunity to comment on the 2024 Notice of Benefit and Payment Parameters and will focus our comments on those areas most important to FQHCs. Our comments are broken into four sections: I. Enhancing Network Adequacy Through Essential Community Providers; II. Reducing Barriers to Enrollment and Financial Assistance; and III. Cuts to User Fees and IV. Increasing Health Insurance Enrollee Protections.

I. Enhancing Network Adequacy Through Essential Community Providers

HealthPoint supports CMS’ proposal at § 156.235 to increase the percentage of FQHCs Qualified Health Plans (QHP) issuers are required to contract with from 30% to 35%. FQHCs are the largest single source of primary care in medically underserved areas and for medically underserved populations. They provide all the necessary health services to help ensure their patients can live healthier lives and increase their overall well-being. Congress designed the Essential Community Providers (ECP) provision of the Affordable Care Act (ACA)¹ to ensure that consumers purchasing coverage on the Marketplace have guaranteed access to trusted providers, which include entities such as community health centers, HIV/AIDS clinics, and family planning health centers. When expansions in health insurance coverage are matched with strong network adequacy protections, patients have more coverage options that connect them with comprehensive, accessible, and qualified community providers to meet their medical needs.

It is important that the Department proactively monitor and enforce QHP compliance with the federal ECP standard and partner with state-based Marketplaces to ensure that plans, including managed care plans, across the nation meet the ECP participation standard. Stronger oversight and enforcement will ensure that families will have adequate access to affordable, quality care provided by health centers, located within their own communities. **HealthPoint** recommends CMS revise the Managed Care reporting template to include more detail on what types of ECPs Managed Care issuers contract with, to ensure that they are indeed contracting with at least 35% of ECPs, and FQHCs, in their service area.

Additionally, to ensure that insurers are contracting with FQHCs, HealthPoint recommends CMS enforce the “any willing provider” statutory provision for QHPs to contract with ECPs. Section 1311 of the ACA states that QHPs “shall... include within health insurance plan networks those essential community providers, where available, that serve predominately low-income,

¹ Section 1311(c)(1)(C)

medically-underserved individuals.” As **HealthPoint** has stated in previous comments, this language clearly requires QHP issuers to offer good-faith contracts to all ECPs, as defined in the statute, located in their service areas. **HealthPoint** CMS enforce this requirement given the statutory language. Currently, CMS mandates that QHPs on FFMs must “offer contracts in good faith to at least one ECP in each ECP category in each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available...”² but given the crucial role health centers play in delivering primary care services, **HealthPoint** believes that these good-faith contracts should extend to all FQHCs in their service area.

HealthPoint recommends CMS enforce this statutory provision of good-faith contracts, which will better ensure FQHCs are being reimbursed at least their PPS rate for QHPs, as well as managed care plans. QHPs are required to pay health centers their Medicaid PPS rate³ unless they have agreed on an in-network, contracted payment rate, which may or may not be equal to the Medicaid rate. For the purposes of Medicaid, this is a comprehensive, bundled, per-visit rate based on the historical costs of Medicaid services in 1999 and 2000. Receiving PPS is central to the successful relationship between FQHCs and their patients and to health centers continued financial viability. [DETAIL ANY ISSUES YOU’VE HAD WITH CONTRACTING WITH QHPS, MANAGED CARE PLANS] Currently, there is no official tracking mechanism for stakeholders, like **HealthPoint** to engage with states and hold them accountable. **HealthPoint** recommends CMS create a tracking system to ensure FQHCs are being reimbursed properly with by the QHPs or managed care plans they contract with.

Notably, Essential Community Providers are also cited as “those who serve predominantly low-income, medically underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act and described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act,”⁴ part of the 340B statute, which grants covered entities access to the 340B Drug Pricing Program. The 340B program allows covered entities to provide more accessible pharmacy services and reasonably priced medications to their patients, because they serve a disproportionate number of lower-income patients. The inclusion of the ECP provision within the 340B statute shows how essential community providers, like FQHCs, are inextricably tied and rely heavily on the benefits of the 340B program. Under the same operating statute, the 340B program and ECP requirements share the same goal: to provide safety net providers with the resources they need to serve the most vulnerable and medically underserved communities. Health centers use their savings through the 340B program to meet the unique needs of health center communities. [CAN REVISE TO BE MORE SPECIFIC WITH WHAT SERVICES YOU OFFER]. 340B savings enable HealthPoint to provide services such as acute care, telehealth, eligibility, dental,

² <https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>

³ Section 1902(bb) of the Social Security Act

⁴ <https://www.cms.gov/files/document/ecp-listing-cover-sheet-03262013pdf#:~:text=Under%20that%20regulation%2C%20essential%20community,of%20the%20Social%20Security%20Act.>

behavioral health, family medicine, women's health, chronic care management, school-based telehealth, patient-only pharmacy, and internal medicine. **HealthPoint's** school-based clinics provide telehealth services through Medpod, facilitated by an onsite Medical Assistant who connects the patient and provider. Our behavioral health providers work with our patients to improve their physical health and mental well-being through providing support, services, and treatment. Our Complex Care Management (CCM) team provides patients with a personal Care Team to assist patients with complex or chronic conditions. Through our patient-only pharmacy, we are able to provide prescription services based on a sliding-fee scale, offering our patients up to a 30% discount on prescriptions. **HealthPoint** filled 33, 686 prescriptions in 2021 and 35,264 prescriptions in 2022. Health centers greatly benefit by participating in a stable 340B program to provide services and resources not funded by reimbursement or non-revenue generating services. It is important for federal agencies, including CMS, understand the implications of the current 340B attacks and the ability for essential community providers like FQHCs to serve Medicaid, Medicare, and Marketplace patients.

II. Reducing Barriers to Enrollment and Financial Assistance

HealthPoint strongly supports the proposed changes—repealing § 155.210(d)(8) and § 155.225(g)(5)— to allow navigators and certified assistant counselors to go door-to-door and provide enrollment assistance. Health centers leverage their trusted relationships in their communities and do the additional work as ECPs to ensure their patients understand health insurance and get enrolled in the most comprehensive services. Under the health center program, every patient completes a financial assessment to determine if they are eligible for sliding fee discounts and health insurance coverage. Health centers employ dedicated staff, such as health navigators, community health workers, and assisters, who help consumers understand and enroll in health insurance coverage options. **HealthPoint** appreciates the Administration for their continued investment in navigators and enrollment assisters as these resources have played an integral role coming out of the COVID-19 pandemic.

Navigators being able to travel to an enrollee's residence enhances the opportunity to get more people enrolled in health insurance coverage. This proposed provision will allow navigators and other types of assisters to better meet patients where they are, hopefully allowing more people to receive health coverage. Health center patients are more likely to experience SDOH that can negatively impact their ability to seek health coverage, especially in person. Impacts such as lacking access to reliable, affordable transportation or having a chronic condition or a disability could impact being able to seek help getting health insurance in-person. Other health center patients may lack adequate broadband access to apply for insurance online or live in rural area where it can be difficult to solicit enrollment assistance. **HealthPoint** appreciates CMS creating more flexibility for navigators and certified assistance counselors to go into the community and reach the patients who need the most support.

HealthPoint also supports the proposal at §155.335 to allow Exchanges to directly re-enroll CSR-eligible enrollees into QHP silver plan from a bronze plan under the same product and QHP issuer. These types of changes allow enrollees to have more comprehensive coverage with potentially fewer out-of-pocket costs without having to spend more money on a monthly premium. On average, health care spending per person was \$12,914 per person in 2021.⁵ With the median U.S. household income reported at \$70,784 in 2021,⁶ that is a large percentage of a person's take-home pay. Instead of spending a significant amount of their income on out-of-pocket costs working towards meeting a high-deductible bronze plan, enrollees can put that money towards food, housing, or improving their quality of life and not avoid care due being underinsured. Finalizing this proposed change will positively impact people by easily granting them better, more comprehensive coverage without costing them extra money.

HealthPoint also appreciates CMS' proposal under § 155.420(d)(1) to give Exchanges the option to implement a new special rule for consumers eligible for a Special Enrollment Period – allowing consumers up to 60 days before their loss of insurance or 90 days after their loss of insurance, to select a plan under the Exchange. Before the continuous coverage provision implemented during the pandemic, 1 in 10 Medicaid/CHIP beneficiaries experienced churn in less than one year.⁷ This can be attributed to lost paperwork, administrative error, or a change in address. Furthermore, while states are doing all they can to prepare for redeterminations, inevitably some notices to enrollees could not make it to enrollees and result in loss of coverage. Ensuring that enrollees have an adequate amount of time to obtain insurance on the Marketplace in the event they no longer qualify for Medicaid/CHIP is crucial. Maintenance of insurance coverage contributes to continuity of care, which helps ensure healthier outcomes for health center patients.

III. Cuts to User Fees

HealthPoint appreciates the Administration's continued investment in the outreach and enrollment workforce, especially CMS awarding health centers \$80 million for 60 navigator programs for the 2022 plan year in 30 states with a Federally-Facilitated Marketplace.⁸ **[INFO ABOUT YOUR SPECIFIC FUNDING, IF YOU RECEIVED IT]** Funding for this workforce is so important for health centers and the patients we serve. While outreach and enrollment services are built in the 330 grant that health centers receive, O/E work is not covered as "billable providers"

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=U.S.%20health%20care%20spending%20grew,trillion%20or%20%2412%2C530%20per%20person.>

⁶ [https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1\).](https://www.census.gov/library/publications/2022/demo/p60-276.html#:~:text=Highlights,and%20Table%20A%2D1).)

⁷ [https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.](https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/)

⁸ <https://www.hhs.gov/about/news/2021/08/27/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcare-open-enrollment-period.html>

and reimbursable services, making the continued funding from the Administration crucial so that health centers can reach more patients. This funding has also provided health centers the necessary resources to assist with upcoming needs related to Medicaid redeterminations. Because states will be able to start Medicaid redeterminations April 1, there are an estimated 5 to 14 million people who could lose Medicaid coverage, likely making them eligible for coverage on the Marketplace.⁹

HealthPoint is concerned that the timing of user fee cuts and the high volume of Medicaid redeterminations can have a negative impact on the workforce and resources required to mitigate the unnecessary churn of consumers. The marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. The HealthCare.gov website, the Marketplace call center, and these consumer-facing functions are critical for health centers across the country because they ultimately impact patient outcomes; more funding leads to a strengthened outreach and enrollment workforce providing services that help increase enrollment in health insurance.

Health centers have utilized marketing and outreach funding under the ACA by incorporating Community Health Workers (CHWs) into their patient care teams. CHWs and enrollment assisters are public health workers who are trusted members of, or are closely connected to, a community. They provide unbiased enrollment assistance and facilitate access to services which improve the quality of care for patients. Unlike CHWs and enrollment assisters funded by the user fees, private navigators and assisters are oftentimes paid commissions by a third party. This third-party creates incentives for private navigators and assisters to direct consumers to certain private products, rather than promoting consumer utilization in a neutral manner. **[SPECIFIC #S ON YOUR CHWS, HOW YOU USE THEM]** CHWs at **HealthPoint** work primarily with our Complex Care Management (CCM) team to follow up and monitor patients with complex and chronic conditions. Our CHWs assist in pre-visit planning, appointment reminders, sending invitations to utilize CCM services, and following up on no-shows. Given that these core marketplace functions are funded by user fees, CMS' proposed changes may create unintended consequences and make it more difficult for consumers to access accurate and comprehensive eligibility information for Medicaid and related programs associated with HealthCare.gov.

While we understand the intent that lower user fees may decrease health care premiums, the reduction in funding will ultimately have a negative impact on the services that connect patients to health insurance coverage. For example, from 2016 to 2019, when outreach and enrollment experienced significant budget cuts, unsubsidized enrollment decreased by 2.8 million people.¹⁰ While those were significant cuts, a cut to funding at a crucial time of redeterminations may

⁹ <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/>

¹⁰ <https://www.cms.gov/newsroom/press-releases/unsubsidized-enrollment-individual-market-dropped-45-percent-2016-2019-0>

negatively impact redetermination efforts. Although these user fees do not go into effect until 2024, states have 12 months to initiate redeterminations and 14 months to fully complete redeterminations;¹¹ this means States will be continuing to complete these determinations into 2024. **[INCLUDE ANTICIPATED # OF REDTERMINATIONS FOR YOUR STATE]** In 2023, Texas Health and Human Services estimates that as many as 3.7 million Texas members will need to have their Medicaid eligibility redetermined when continuous coverage ends.¹⁸ These Federally-Facilitated Marketplaces and State-Based Marketplaces will need the financial support to enrollment, which is funded in part by these user fees.

Rather than cutting the user fee, HealthPoint they remain at their current percentages: 2.5% in the marketplace 2.25% in the state-based marketplace. HealthPoint also advocates strongly for CMS to invest more in outreach and enrollment services in general. If there was more federal funding that supported outreach and enrollment services, health centers and other community providers would not rely as much as user fees. In particular, the outreach capabilities would assist health centers in continuing to employ neutral navigators who provide accurate, unbiased information. Further investment in enrollment assistance programs would reduce burden on the safety net and generally ensure better public health, because having health insurance is associated with increased access to health services and better health monitoring.^{12 13 14} States need to be offered additional funding in order to keep up with the anticipated large number of Medicaid redeterminations, as stated earlier. Health centers will play a crucial role in helping enrollees understand their new coverage and adequate funding will help bolster the workforce during this time.

IV. Increasing Health Insurance Enrollee Protections

HealthPoint supports CMS' proposal to amend §155.220(j)(2)(ii) to require web brokers submit additional documentation when submitting their health insurance application. By requiring documentation confirming that all enrollment application has been reviewed by and confirmed as accurate by the consumer or their authorized representation before application submission, this will protect consumers' interests as they choose insurance on the Marketplace. Given that brokers and agents are commission-based, unlike Navigators who are trained to provide unbiased opinions, this could pose a problem for enrollees especially given that these interactions are oftentimes web-based. While no report states the exact number of instances where web brokers

¹¹ [Key Dates Related to the Medicaid Continuous Enrollment Condition](#)

¹² Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713–1722.

¹³ McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. *JAMA*, 290(6), 757–764.

¹⁴ Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. *Medical Care Research and Review*, 62(1), 3–30.

sign enrollees up for different coverage than promised or without their consent,¹⁵ there have been reports of people discovering they obtained Marketplace coverage without their knowledge. **[INCLUDE SPECIFIC EXAMPLES OF ISSUES PATIENTS HAVE HAD WITH BROKERS, IF APPLICABLE]** For example, a 2015 case found that web brokers were signing up people experiencing homelessness and putting down questionable incomes for the enrollees, allowing them to receive zero-premium plans.¹⁶ While many health center patients seek out enrollment assistance from health center outreach and enrollment staff, adding these protections will enhance the integrity of web-brokers and protect enrollees, like health center patients, who choose to use their services.

HealthPoint supports the first CMS proposal in § 156.202 to limit the number of non-standardized plan options that QHP issuers may offer through the Federal Exchanges to two non-standardized plan options per product network type and metal level (excluding catastrophic). When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6 in 2023.¹⁷ While the majority of Marketplace plans are standardized, this change will help streamline and overall simplify the selection process for enrollees. It will also help simplify the process for any assisters or navigators who are helping consumers browse their options.

Similarly, HealthPoint applauds CMS for its proposal to revise § 156.201 to require insurers to place covered drugs in the appropriate formulary tier, and HealthPoint also agrees that four tiers in a plans' drug formulary is sufficient. This will help patients when shopping for plans by keeping a standardized, more simplified system so they can more easily compare coverage options. It is important that individuals thoroughly understand their prescription drug coverage, given that even with the help of insurance, patients still struggle to afford the medication they need. Health centers provide their patients with affordable, accessible medications and other pharmacy services, in-house and/or contracting with pharmacies directly in their patients' community. Because of the 340B program, health centers can offer services such as copayment assistance programs to help lower the financial barrier patients may face when getting prescriptions. **HealthPoint** appreciates CMS' intent to ensure patients can more easily determine which plan is right for them so patients can access the drugs they need through health centers or other providers.

HealthPoint also supports § 156.270(f), which adds a timeliness standard by requiring issuers to send notices of late payment promptly and without undue delay; this will help better ensure

¹⁵ <https://www.npr.org/sections/health-shots/2022/01/17/1073282236/some-insurance-brokers-enroll-people-in-aca-plans-without-consent>

¹⁶ <https://khn.org/news/aetna-breaks-ties-to-man-who-sold-policies-to-hundreds-of-homeless/>

¹⁷ <https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

¹⁸ <https://www.hhs.texas.gov/sites/default/files/documents/mcs-covid-19-info-handout-may-5-2022.pdf>

consumers' continuity of coverage and assure access to health care services. **HealthPoint** appreciates CMS recognizing how administrative functions can impact continuity of coverage and supports the proposal to add timeliness standards in sending late payment notices. If an enrollee is unaware of their late payment due to lack of sufficient correspondence, this protection will help protect enrollees and ensure their insurance is not unfairly terminated. Health center patients are lower-income and experience more social determinants of health that could impact their ability to make timely payments. Factors like unstable housing or lack of reliable broadband access could negatively impact a patient's ability to either pay on time or receive notice about a late payment. Getting that notice to enrollees expediently, and by utilizing different methods of contact, will increase the chances of receiving notice and decrease the chance of their health insurance being revoked.

HealthPoint recommends insurers send notice of payment immediately after the deadline, using the enrollees' preferred methods of contact, and embed the delinquency notice within future payment reminders to help mitigate the chance that one outstanding bill could trigger total insurance loss. Ensuring enrollees are notified multiple times, using multiple contact methods, is in line with proposals outlined in the Administration's proposed rule "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes."

Another enrollee protection HealthPoint supports is the Administration's proposal (§ 155.305(f)) to not deny an enrollee APTC based on IRS data that a consumer failed to pay their previous year's APTC, unless the enrollee has failed to do so in the past two years. Especially given the backlog experienced at the IRS and many other governmental agencies during the pandemic, this slight administrative change lends heightened protection to more financially vulnerable enrollees who are supposed to qualify for APTCs. Furthermore, as cited in the proposed rule, Exchanges still face operational challenges and enrollees should not be financially penalized in the case of an unintentional technical issue within the Exchange. Over 20% of health center patients have private insurance coverage and this change will positively promote continuity of coverage for them.

The provisions in this proposed rule will positively impact health center patients' access to quality, affordable health coverage and care through enhanced access to services, simplifying plan choice and the selection process, and easing enrollment in coverage. We greatly appreciate the opportunity to provide comment on this proposed rule. Should you have any questions about our comments, please feel free to contact **[YOUR POLICY DIRECTOR INFORMATION]**

Sincerely,

[SIGNATORY]



January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: CMS-9899-P

Dear Administrator Brooks-LaSure:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefit specialists. We are pleased to respond to your proposed rule titled "2024 Notice of Benefits and Payment Parameters," published in the *Federal Register* on December 21, 2022.

The members of NABIP work daily to help millions of people purchase, administer, and utilize health insurance coverage, including individuals purchasing private individual-market coverage and employers of all sizes who are designing and purchasing group coverage for their employees and their dependents. As such, we are pleased to be able to provide comments on the proposed rule. To develop our comments, we sought input from members who specialize in individual-market sales, as well as those who work directly in group employee benefit plan compliance. We grouped our comments by topic, as addressed in the proposed rule.

Prescription Drug Cost-Sharing Tier Placement

The federal exchange marketplace uses four standard tiers of prescription drugs for its formularies: generic, preferred brand, non-preferred brand and specialty drugs. The proposed rule would not only retain this tier structure, but also require all issuers to place covered drugs in the appropriate cost-sharing tier unless there is an "appropriate and non-discriminatory basis" for placing the drug in the specialty tier instead. This change is proposed to address complaints of discriminatory placement of medications on high-cost tiers by certain issuers, and NABIP supports the proposal.

Limits to Standardized Plan Options or Meaningful-Difference Changes

To reduce consumer confusion, the proposed rule would limit the number of non-standardized plans that issuers can offer through the federally facilitated exchange or state-based exchanges that utilize the federal marketplace platform to two per product, network type and metal level, by service area. Based on the proposed rule's own estimates, this change would cause



approximately 2.72 million current enrollees to have their plans discontinued in 2024, requiring issuers to place all these individuals in new coverage options.

As an alternative, the rule also contemplates reinstating the “meaningful-difference standard” that issuers were required to abide by several years ago. According to that standard, plans designs offered by issuers had to be different enough that an exchange shopper could easily differentiate between them. However, the proposed rule considers an even stricter standard, proposing to group plans by issuer ID, county, metal level, product network type and deductible integration type, and then evaluate whether plans within each group are meaningfully different, based on differences in deductible amounts of at least \$1,000. The proposed rule seeks comments on both potential approaches.

NABIP members assist consumer in evaluating coverage options every day, so our members understand the overwhelm exchange consumers without adequate guidance may feel when confronted with dozens of seemingly similar plan choices. However, our membership also values the innovation and price controls increased plan competition brings, and believes that consumers should have a wide range of plan choices available to ensure their coverage needs are truly met. CMS’s own ZIP Code-based enrollment data shows that the highest rates of exchange coverage take-up come in ZIP Codes with the greatest number of plans participating in the marketplace, offering the greatest number of plan choices. Therefore, we can conclude that too many plan options is not an actual barrier to enrollment in coverage.

Instead, we believe that it is the consumer’s lack of ability to sort through and compare plan options easily, based on their most important coverage values. Accordingly, we recommend a third approach, one that is utilized in many state-based exchange, including Pennie and Covered California. That approach involves using technology and the customers’ preferences to narrow down plan choices and lead them to the most appropriate products. Multiple state-based exchanges ask enrollees to complete a coverage survey before beginning the enrollment process, and the answers to those survey questions filter and sort the plan results made immediately available to the prospective enrollee. NABIP members recommend the federal exchange utilize a similar approach. We suggest the use of approximately five short questions to gauge coverage preferences, focusing on the following topics: (1) any preference toward lower premiums versus lower up-front cost-sharing; (2) average coverage utilization and need for broad-based benefit design; (3) any preference toward specific providers and/or a broad or narrow network; (4) prescription drug needs; and (5) preferences toward subsidy amounts and cost-sharing assistance. Should your agency elect to utilize all or part of our proposed design, our members who work with individual consumers on their coverage needs would be happy to assist you in developing and testing potential coverage-assessment questions.

Plan Names

The proposed rule would prevent the use of misleading plan names for marketplace-qualified health plans by requiring a review of names plans are marketed under during the annual QHP certification process, in collaboration with state regulators. NABIP members support this proposed change.

Marketplace Plan Network Requirement

Currently all marketplace plans, apart from those that do not utilize a provider network, must abide by network-adequacy and essential-community-provider standards. The proposed rule would require all plans to use a network and abide by those standards. NABIP members note that this proposed change would eliminate the potential of reference-based pricing plan options from being sold in the exchange marketplace. However, given the rarity of those plans generally, and the data provided in the preamble to the proposed rule noting that since 2016 only one FFM issuer has offered a plan that does not use a provider network, NABIP members do not oppose this proposed change.

Dependents to Age 26

The federally facilitated exchange marketplace has a longtime practice of requiring issuers that cover dependent children to maintain that coverage until the end of the plan year in which they turn 26. This proposed rule would codify that operational practice for clarity's sake. State-based exchanges could implement a similar rule at their option. Any advance premium tax credits will continue to be paid during this time. NABIP members support this codification.

Establishing a Timeliness Standard for Notices of Payment Delinquency

When a plan enrollee becomes delinquent in making premium payments, current rules require issuers to send a delinquency notice, giving the enrollee appropriate time deal with unpaid premiums and avoid coverage termination. Since market examinations and audits have revealed that certain issuers are not sending delinquency notices in a timely fashion, the proposed rule contemplates enforcing a delivery timeframe and seeks comment on such a timeframe. NABIP members believe exchange consumers should have at least 30 days to correct any unpaid premium balances prior to termination.

Allowing Door-to-Door Assistance

The proposed rule would repeal current federal rules that prohibit navigators, certified application counselors and other enrollment assisters from going door to door or using unsolicited means to provide enrollment assistance to consumers. NABIP members vehemently oppose this proposed repeal of the prohibition on door-to-door solicitation.

Our association understands the concerns about enrolling transportation-challenged and immunocompromised people addressed in the preamble to the proposed rule. However, we

note that these concerns could be addressed through the use of technology, and allowing door-to-door assistance could actually put vulnerable potential exchange consumers at further risk. Not only does the proposed repeal create safety concerns for both potential enrollees and those who may approach strange homes to attempt to enroll people, it also increases the likelihood that exchange enrollees become the subject of fraud or feel pressured to make quick and inadequate enrollment decisions. Most important, allowing for door-to-door exchange coverage enrollment denigrates the product and financial decisions at stake. When selecting an exchange plan option and applying for premium tax credits, consumers need to make critical financial and health decisions that will affect their personal and monetary wellbeing for at least a year. This process should not be put on the same level as ordering cookies for delivery.

NABIP members note that when the Medicare Advantage marketplace first came into fruition, unsuspecting consumers were besieged by door-to-door solicitations by unscrupulous actors. The consumer backlash was enormous and immediate. CMS quickly banned the practice and has not looked back. It would seem unfathomable that your agency is considering allowing such a practice now for exchange-based consumers.

Rules for Brokers and Agents

The proposed rule would establish new requirements for agents, brokers and web-brokers by mandating they document that their clients (or authorized representatives) have reviewed and confirmed their eligibility information before they apply for exchange-based coverage. CMS has offered a draft model form for brokers and agents to use, and the proposed rule would require them to maintain this documentation for at least 10 years and be able to provide it to HHS upon request. The proposed rule would also require FFM and SBM-FP agents, brokers and web-brokers to document that they have received consumers' consent to assist them with a marketplace-eligibility application.

NABIP members, who would be directly affected by this new requirement, appreciate the need to verify eligibility information and consent for brokers to help individuals with their coverage needs. Additionally, we appreciate that, following the release of the proposed rule, CMS proposed a sample template document for brokers to use when documenting client consent and eligibility.

However, NABIP members feel strongly that requiring brokers to obtain and maintain such consents is not truly in the best interest of the consumer. In fact, an unscrupulous actor could easily create fraudulent consent documents and/or complete them for clients after the fact, especially since consent could take the form of either a signature or a voice recording, which could easily be faked. Instead, NABIP members would like to see a consumer's eligibility review and consent to use a broker for assistance to be built into the exchange application process, with the record-keeping becoming part of the person's official application maintained by the federally facilitated marketplace. That way, the data will be consistently available, the consent approaches



will be uniform, and all entities that assist consumers with coverage enrollment can verify consumer eligibility and assent.

Should the exchange marketplace receive notification of a change to the broker of record on an individual's account, then NABIP members propose that the exchange assume that such a transaction is valid, given that they will have the new broker's unique identifier in their national producer number (NPN) for verification and tracking purposes. In this case, NABIP proposes that the exchange consumer receive an automatic communication from the federally facilitated marketplace, ideally in writing, although electronic mail or text-messaging could be used. This notification could alert consumers to a potential change to their broker of record and inform them how to contact the exchange to rectify the matter if they did not authorize the change. NABIP members believe these simple changes to the application process would provide consumers with greater protection and peace of mind and allow CMS to better monitor broker behavior.

Income Attestations

When individuals apply for exchange-based premium tax credit subsidies, their stated income is typically verified by the exchange using tax data from the Internal Revenue Service. However, under certain circumstances, tax data is not readily available. Currently, the exchanges must treat missing tax data as if the tax data is inconsistent with the individual's stated income and create a data-matching issue to resolve. Should they fail to resolve it within 90 days, the plan premiums adjust to full cost, starting the month following the 90-day deadline.

The proposed rule would allow an individual's income attestation to stand if the tax data is truly not available, thereby not affecting the subsidy process. While our association notes that this proposal does generate minor fraud concerns, overall, this policy change is likely to help more consumers than it will result in the issuance of fraudulent tax credits. Given there are often legitimate reasons for missing tax data, using the attestation will be quicker and more accurate in most cases. Further, if an individual receives an excessive tax credit because of a faulty attestation, that will ultimately be adjudicated anyway.

Data-Matching Issue Timeline Extension

The proposed rule would give all exchange consumers a 60-day extension for resolving income-based data-matching issues. NABIP members support this proposed change.

Special Enrollment Period Changes

The proposed rule would allow for changes to exchange-based special enrollment periods (SEPs). The first would allow exchanges to require issuers to start coverage one month earlier in cases where the old coverage ends before the end of the month, to avoid gaps in coverage. If a consumer reported loss of coverage and chose a plan during the month before the old coverage ended, the proposed rule would also allow exchange coverage to begin on the first day of the

month during which the old coverage expired. The second change would extend from 60 to 90 days the window Medicaid recipients have to enroll in exchange coverage when they lose Medicaid eligibility. NABIP members support both proposed changes and note they will likely serve consumers well once the National Health Emergency ends and millions of individuals will lose their Medicaid eligibility and potentially suffer gaps in coverage.

Auto-Enrollment Changes

The proposed regulation would change the rules the federally facilitated exchange marketplace uses to auto-enroll individuals who do not proactively reenroll in their exchange-based health insurance coverage. If finalized, this regulation would change the reenrollment decision-making hierarchy in two ways. The first would allow the exchanges to switch consumers who do not proactively reenroll from a bronze-level plan to a silver-level plan so that the consumer would benefit from cost-sharing reductions, even though that means their monthly premiums could be higher. This proposed change would be allowed even if the consumer's bronze plan was still on the table, as long as the silver premium net of APTC was no greater than the bronze premium. The second change would allow for a change to the reenrollment hierarchies to factor in a preference for keeping individuals in provider networks that are like their current plan. The proposal also asks for comments on changing the auto-enrollment system and hierarchies in a wide range of other ways.

NABIP members have long expressed concern about the federal exchange's policy of re-enrolling individuals into exchange-based coverage if they do not enroll themselves proactively. Our members especially find the practice of mapping consumers into new coverage options that they did not expressly pick, without discussing other options with them first problematic. We have a particular concern with the first described proposed change, which would discount an individual's choice of coverage with a potentially lower premium even though that plan could potentially still exist. Consistent with our prior-year comments, NABIP members would prefer that all exchange consumers re-visit their benefit choices yearly with a licensed professional so that we can be assured that consumers' enrollment choices truly meet their needs, preferences and budgets.

Making the Timeframe for Creating a State-Based Exchange More Flexible

The proposed rule would reduce the amount of time a state seeking to create its own state-based exchange from at least 14 months before the state's first proposed open-enrollment period for a full state-based exchange and two months beforehand for those states seeking to move to a state-based model using the federal technology platform. States would retain the same blueprint-submission timeframe, but approval or conditional approval would now be required before the first OEP rather than months in advance of it.

NABIP supports this proposed change to the state-based exchange blueprint-approval timeframe. Our membership has been extremely supportive of the creation of state-based



exchanges, and thousands of our members nationwide serve these markets, both as agents and brokers, and as members of exchange advisory boards and in other capacities. We believe allowing states to gain quicker federal approval for state-based exchange marketplace endeavors will benefit local individual market consumers.

Exchange User Fees

The proposed rule would reduce the user fees for issuers that participate in the federally facilitated exchange marketplace and state-based exchanges utilizing the federal marketplace technology platform. The .25% reduction for each type of exchange reflects a general trend of reducing the exchange user fees, and NABIP members support it, as it will have a positive impact on both the competitive marketplace and consumer prices.

NABIP members appreciate the opportunity provided by CMS to respond to this RFI. If you have any questions about our comments, or if you need additional information or assistance, please do not hesitate to contact me at either jtrautwein@nabip.org or (202) 595-0639.

Sincerely,

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Benefits and Insurance Professionals

PUBLIC SUBMISSION

As of: 1/31/23, 12:23 PM Received: January 30, 2023 Status: Posted Posted: January 31, 2023 Tracking No. ldj-ml2-rcw8 Comments Due: February 13, 2023 Submission Type: API

Docket: CMS-2022-0192

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

Comment On: CMS-2022-0192-0003

Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2024

Document: CMS-2022-0192-0270

Comment on CMS-2022-0192-0003

Submitter Information

Name: Ahmad Khdeir

General Comment

See attached file(s)

Attachments

CMS

Ref: 2022-27206 CMS Comment Period related to:

[CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024](#)

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear: Xavier Becerra, 25th United States Secretary of Health and Human Services
Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services
Dr. Ellen Montz, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services

I am writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. I appreciate the opportunity to provide comments on this important proposed rule.

I am a licensed independent health insurance agent/broker serving the great state(s) **TX, TN, IL, OH, MI, FL, NC, AZ**. **This is my first year being an agent, I have been through many careers before, but being an agent has changed my life. Because of this position I was able to listen to people, understand their needs, and do my best to help them. I was happy to help people who do not write and speak in English, people who have a hard time understanding the health insurance and the many options available to them. When I help people, I feel happiness and I feel successful, and these feelings motivate me to learn more and more so I can help people who always need help. And because of this position I was able to help, support and take care of my family and my new baby girl Ayah.**

I have evaluated the proposed rule and have comments to offer regarding the following topics.

- Section 155.210(d)(8) Navigator Marketing
- Section 155.220(j) Requirements of the Agent/Broker Community

Section 155.210(d)(8) Navigator Marketing:

I want to articulate my concerns about the probable impact of eliminating subsection (d)(8) of 45 CFR § 155.210 from the ACA. As you may know, this provision currently prohibits navigators from conducting door-to-door enrollment activities.

- I believe that removing this provision could have several adverse consequences.
- Allowing navigators to conduct door-to-door enrollment could cause concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from navigators. It could also lead to confusion or misunderstandings about the nature of the assistance being offered. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.
- Like the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.
- Lastly, I feel very strongly that both Navigators and Brokers have a separate and distinct roles within the health insurance market for individuals. For example, consumers with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Agents or Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but

not Agents and Brokers, you are keeping a better qualified resource, the Agent or Broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

- I urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Section 155.220 Requirements of the Agent/Broker Community:

- **Providing Correct Information to the FFs (Section 155.220 (j))**
 - I am concerned with the additional burden placed on the Agent/Broker community by adding another requirement to assist consumers with health insurance.
 - As the ACA was signed, Agent/Broker commissions dropped more than 50%. Currently, I am working under reduced commission schedules and on average I receive \$10-\$30 per policy, per month.
 - This additional burden will reduce my overall income to support my staff and allow me to continue to assist consumers.
 - I believe with the tremendous number of emails, texts and mail consumers currently receive from CMS, web-brokers, they are certainly aware of the plan they have chosen. Not to mention the fact, I meet with each client to discuss their personal and specific needs. It is a complex enrollment process in which we are paid a minimal fee of \$10-\$30 per policy, per month. If you calculate my time, divided by commissions, minimum wage is hard to attain.
 - Finally, I question how a small Agent/Broker will be able to fund these new regulations and the requirement to store the documentation for 10 years.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs currently in place to solidify this information.
- **Section 155.220 (j)(2)**
 - I am concerned with this section, implying that I am not submitting correct information. I agree correct information should be used when applying for health insurance. Wouldn't it be easier to approach those Agent/Brokers who have caused you to create this proposed rule.
 - Under Section 1411(h), I feel the imposing civil penalties on an already over regulated, overburdened industry is unfair.
 - I would suggest the web-brokers and CMS to utilize the text/email/mail programs currently in place to solidify this information
- **Section 155.220(j)(2)(ii)**
 - I understand the importance to provide correct information with the regard to income and erroneous social security numbers. The ACA requires consumers to "make their best guess" regarding income. This "guess" can be complex for the self-employed consumers.
 - The Federal Marketplace is connected to the IRS, which should/could help in providing correct income information.
 - The Federal Marketplace currently asks for proof of income and proof of citizenship, i.e., copy of social security card, license, etc.
 - The ACA legislation inserted countless rules regarding income. This new rule appears to put an additional burden on the Agent/Broker community. We are not considered our clients legal counsel and can only input the information we are provided.
 - If there are agents providing incorrect information, they should be addressed individually without adding an additional burden for the entire industry.
 - I personally find when citizenship information does not match, the application is flagged, I reach out to my client and assist them in uploading the required documentation.
 - I would suggest the web-brokers and CMS utilize the text/email/mail programs you already have in place to solidify this information.

- **Section 155.220(j)(2)(ii)(A)**
 - I understand the importance of inputting correct eligibility information, however, again I am concerned regarding the undue burden it will put on the Agent/Broker community.
 - I appreciate the fact, you are not requiring a specific method of attestation, however, the additional rules and regulations put on my industry will cause more agents to get out of the market.
 - An acceptable method would be to use the processes you have in place with the web-brokers and CMS to utilize the text/email/mail programs they already have in place to solidify this information
- **Section 155.220(j)(2)(ii)(A)(1)**
 - To reiterate my comments above, I feel you can use the processes you have in place with web-brokers and CMS to send a text to the consumer to answer yes to each of your concerns. Example: Correct plan chosen, correct projected income, my Agent/Broker is correct.
 - I am concerned with the words, “under penalty of perjury.” I work in a highly regulated industry. Not only am I highly educated, required to pass all CMS educational programs, required to complete Continuing Education hours within my State, carry Errors and Omissions insurance and personally and professionally hold myself to the highest regard of integrity.
 - I personally make notation of the date and time that I speak to my clients and again this should be documented by the web-brokers and CMS when the application is completed.
 - Please keep in mind, many consumers do not have access to computers, most have access to phones.
 - With the fact everything should be kept with the web-brokers and CMS, I am concerned with the requirements of keeping this information for 10 years.
- **Section 155.220(j)(2)(ii)(B)**
 - This section is speaking about an issue that is happening across the nation to many professionals.
 - I know colleagues who have had a “rouge” agent steal their clients.
 - Currently, we are required to report this individual, the client is willing to file suit, however, we are not aware of agents being removed from the FFM system.
 - This can be simply corrected, if a text/email goes to the consumer stating, is John Doe your agent, they will answer yes or no.
 - Again, I feel this rule is taking a broad brush to an important problem. If the bad agents were address, the good ones would not be punished.
 - When CMS and the web-brokers send an email asking folks to pick a plan (when they have absolutely picked a plan already), they can add is John Doe your agent?
 - Also, please note, when the consumer policy is taken, we lose commissions, and it may take several months before we obtain our commissions again.
 - We need help in this area but requiring additional paperwork doesn’t seem like the answer.

I would like to thank you for reviewing my comments and would be happy to provide more information. I think if we work together, we can protect the consumers, which is of utmost importance to me and my industry.

Sincerely,

January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

Re: CMS-9899-P – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 — Comments

Dear Administrator Brooks-LaSure:

eHealth Inc. appreciates this opportunity to offer comments, observations and considerations on CMS-9899-P, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters Proposed Rule. For more than 25 years, eHealth, Inc. and its subsidiaries (“eHealth”) have served American consumers with innovative technology and licensed agent support to help them find health insurance solutions that fit their personal needs. Through its proprietary health insurance marketplaces, eHealth has connected more than eight million members with quality, affordable coverage from approximately 200 health insurance companies nationwide. Along with individual, family, small business, and ancillary plans, eHealth also offers Medicare Advantage, Medicare Supplement, and Medicare Part D insurance plans.

eHealth is a member of the Association of Web-Based Health Insurance Brokers, whose members leverage the Federally-facilitated Exchange’s (FFE) Direct Enrollment and Enhanced Direct Enrollment application programming interfaces (APIs). We wish to align ourselves with AWHIB’s submitted comments on this proposed rule and to highlight three priority topics:

1. A requirement (45 CFR §155.220(j)) that agents/brokers and web-brokers assisting applicants document that eligibility information has been reviewed and confirmed by the consumer.
2. A requirement (45 CFR §155.220(j)) that agents/brokers and web-brokers assisting with customer enrollment document the receipt of consumer consent.
3. A requirement (45 CFR §156.202) that an issuer be limited to offering only two non-standardized plans per product network type and metal level.

eHealth asks the Department to consider the following recommendations and perspectives as it finalizes the proposed rule.

(1) Providing Correct Information to the FFEs (45 CFR §155.220(j))

CMS proposes to revise §155.220(j) to require agents/brokers and web-brokers assisting individuals applying for APTC and CSRs document that the eligibility application information has been reviewed and confirmed by the consumer or their authorized representative prior to application submission. The documentation would:

- Require the consumer to take an action, such as provide a signature or recorded verbal confirmation.
- Need to include the date of review, the name of consumer or authorized representative, explanation of the “penalty of perjury” attestations at the end of the application, and name of the agent/broker or web-broker.
- Need to be maintained for 10 years.

Comment

eHealth recommends that the proposed standard not apply when consumers are completing the application themselves using a web-broker’s website in self-service mode.

eHealth further recommends that CMS share complaint rate data regarding the accuracy of applications completed by agents/brokers and web-brokers versus other Marketplace channels, such as the Marketplace Call Center, Healthcare.gov and navigators and assisters to help support whether the proposed standard is needed.

The proposed documentation is unnecessary when consumers are completing the application on their own without the assistance of an agent or broker. Further, eHealth has concerns that the documentation requirements would add unnecessary friction and reduce enrollment conversion rates, effectively reducing access to coverage. We also note the imbalance with the user experience on Healthcare.gov, where consumers would presumably not be required to complete the additional documentation step.

Should CMS codify the proposed standard, eHealth concurs with not specifying the specific method and providing agents/brokers and web-brokers with flexibility on how best to collect, record and store the documentation, as well as where confirmation should be collected from the consumer. This flexibility would help web-brokers determine how best to incorporate the confirmation and documentation process efficiently within the application and enrollment experience.

We further concur that an application filer be able to review and confirm accuracy on behalf of other applicants on the same application. This is consistent with the rest of the application process and is far more workable than requiring each applicant to review and confirm application accuracy.

(2) Documenting Receipt of Consumer Consent (45 CFR §155.220(j))

CMS proposes to revise 45 CFR §155.220(j)(2)(iii) to require agents/brokers and web-brokers assisting with enrollment through FFEs or SBE-FPs, or assisting an individual in applying for APTCs and CSRs, to document the receipt of consumer consent. The consent provision would:

- Require the consumer to take an action, such as provide a signature or recorded verbal confirmation.
- Require the agent/broker or web-broker to document the date of consent; name of consumer or authorized representative; name of agent, broker or web-broker to which consent is granted; include the scope, purpose and duration of consent; include the process for rescinding consent.
- Require consent documentation be maintained for 10 years.

Comment

eHealth recommends that CMS permit flexibility on how to collect, document, revoke and store consumer consent.

We further recommend that consumers be able to grant consent to multiple agents/brokers and web-brokers simultaneously, and that consent be considered terminated only if limited by a specific duration or if specifically rescinded.

eHealth recognizes the importance of obtaining consent when assisting consumers in completing their application and enrollment and wants to ensure that the process of providing consent is clear, workable and efficient with minimal unnecessary friction.

Should CMS codify the proposed standard, eHealth recommends that CMS provide discretion to web-brokers not only for the method for collecting consent, but also where consent can be collected and the scope, purpose and duration of the consent which may vary based on the business model of the web-broker. For example, the method and location for collecting consent may differ based upon whether the consumer is working with a web-broker in self-service mode, or whether they are working with an agent using the web-broker's platform. Additionally, the scope, purpose and duration may differ depending upon whether the consumer is working with an agent/broker that only supports enrollment in Marketplace coverage versus an agent/broker like eHealth which offers a range of insurance products in addition to Marketplace coverage (e.g., dental, vision, ACA-compliant plans outside the Marketplace, and other ancillary coverage).

Further, attempting to limit consent to a single agent, broker or web-broker at any given time could be difficult to manage. Establishing and recording consent, even with multiple entities at the same time, would establish a record of the entities with whom the consumer intended to work on his/her behalf.

(3) Limits on Non-Standardized Plan Options (45 CFR §156.202)

CMS proposes to amend 45 CFR §156.202 to limit a QHP issuer to offering only two non-standardized plan options per product network type and metal level in a given service area.

Comment

eHealth recommends not finalizing the proposed limit on QHP issuer non-standardized plan offerings.

While we recognize concerns about consumers sifting through a high volume of plans with minimal benefit and/or network differences, eHealth believes that imposing a limit of two plan options per product network type and metal level is arbitrary and could constrain issuers' ability to offer innovative plan designs.

eHealth instead proposes that CMS consider reinstituting previously codified "meaningful difference standards" to strengthen distinctions between non-standard plan options while preserving issuer ability to offer innovative plan designs. Under the prior standard, a plan was considered "meaningfully different" from another plan offered by the same issuer if a consumer could reasonably identify material differences between plan characteristics such as cost sharing or out-of-pocket maximum; provider network; covered benefits; plan type; HSA eligibility; or self-only, non-self-only, or child-only offerings. Furthermore, web-broker decision support tools can help consumers and their agents sort through the available options (both standardized and non-standardized) and identify a plan or set plan options that best meet the consumer's needs.

Closing

eHealth appreciates the opportunity to offer comments on the proposed rule. We look forward to continuing to partner with CMS and states in enrolling consumers into health insurance coverage which meets their unique needs and circumstances.

Sincerely,

A handwritten signature in black ink, reading "Kate Sullivan". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate Sullivan
Vice President, Government Affairs
eHealth, Inc.