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.

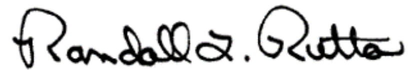
Income Attestation for Premium Eligibility

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,



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