



January 8, 2024

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 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program; CMS-9894-P, RIN: 0938-AV22

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 "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program" (2025 NBPP).

Created by and for patient organizations over 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, equitable, and sustainable health care. Made up of 170 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 and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

Need for New Shopping Tools on HealthCare.gov

Many of the issues raised in the 2025 NBPP, such as 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 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.

Furthermore, to complement these enhancements, it is imperative to integrate comprehensive, user-friendly educational resources on HealthCare.gov. These resources should aim to clarify insurance terms and concepts, aiding consumers in navigating the complexities of selecting a health plan. Interactive tools can help users understand how premiums, deductibles, copays, and coinsurance impact their health care expenses. Such educational support is crucial in empowering consumers, particularly those with chronic conditions and disabilities, to choose health plans that best meet their individual health and financial needs.

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.

Overview of NHC Comments

The NHC extends its gratitude to CMS for their 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 recognize and support CMS’ efforts in the 2025 NBPP, emphasizing the critical importance of patient-centricity in policy decisions, and advocate for ongoing engagement with patients, patient groups, and other stakeholders to continuously refine Marketplace policies. The following is an overview of the NHC’s comments on proposals in the 2025 NBPP.

1. **Section 1332 Waivers:** The NHC supports the proposed changes to Section 1332 Waiver Public Notice Requirements and its importance in increasing public engagement and inclusivity, especially by incorporating virtual and hybrid public hearing formats, to facilitate broader participation from diverse groups including patients with chronic conditions or disabilities, or those living in remote areas.
2. **Risk Adjustment Models:** The NHC recommends that CMS regularly reevaluate the HHS-Hierarchical Condition Category (HCC) risk score model to incorporate patient perspectives to ensure the model’s sensitivities to the complexities of complex conditions and accurately reflect health care costs and ensure financial stability for insurers.
3. **State Exchange Approval:** The NHC supports the amendment requiring states to operate as a State-based Exchange using the Federal platform (SBE-FP) for at least one plan year before transitioning to a State Exchange and views it as a crucial preparatory step for successful marketplace management, emphasizing the importance of network adequacy and consumer assistance during this period.
4. **Additional Required Benefits:** The NHC supports the proposed amendment that would allow benefits in a State’s Essential Health Benefits (EHB)-benchmark

plan to be considered EHBs and not subject to state defrayal from plan year (PY) 2025, simplifying health care coverage, reducing administrative burdens, and ensuring consistent protections for essential health services, particularly benefiting patients with chronic conditions or complex health needs.

5. **Consumer Assistance Tools:** The NHC supports requiring all Exchanges to provide live call center assistance during operational hours, ensuring real-time aid for Qualified Health Plan (QHP) applications and understanding of Advanced Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSR), especially for those with chronic conditions.
6. **Centralized Eligibility and Enrollment Platform:** The NHC supports the amendments for Exchanges to operate a centralized eligibility and enrollment platform, streamlining QHP enrollment and benefiting individuals with chronic conditions or complex needs, ensuring consistent and reliable access to health care coverage.
7. **Agents, Brokers, and Web-Brokers:** The NHC supports the amendment to standardize the display of QHP information and disclaimer requirements by web-brokers across State Exchanges, aligning with HHS standards in Federally-facilitated Exchanges (FTEs) and SBE-FPs, ensuring consistent information and service quality for consumers, essential for reducing confusion and misinformation in the health insurance marketplace.
8. **Direct Enrollment (DE) Entity Compliance:** The NHC supports the proposal requiring DE entities to align their non-Exchange websites with HealthCare.gov changes, ensuring consistent information and timely updates as directed by HHS, crucial for maintaining a unified and accurate national health insurance enrollment framework.
9. **Failure to Reconcile (FTR) Process:** The NHC views the proposed changes to the FTR process positively as safeguarding consumers' health coverage access, particularly for those with chronic conditions, by enhancing education, aligning with consumer protection principles, and ensuring clarity and accessibility in communication strategies.
10. **Incarceration Verification Process:** The NHC supports proposed changes which streamline the health insurance enrollment verification process for individuals with a history of incarceration, easing access to health care for this group reducing administrative burdens, and promoting a consumer-centric and efficient verification system.
11. **Eligibility Redetermination and Insurance Affordability Programs:** The NHC supports the proposed amendments which enhance the efficiency and accuracy of eligibility determinations for insurance affordability programs by enabling State Exchanges and Medicaid/Children's Health Insurance Program (CHIP) agencies to access income data through the Federal Data Services Hub, expected to significantly improve the integrity of the income verification process, crucial for accurately determining program eligibility.
12. **Catastrophic Coverage Auto Re-Enrollment:** The NHC supports the inclusion of catastrophic plan enrollees in the auto re-enrollment process ensuring continuity in health coverage for individuals who may not actively select a new plan, addressing a significant gap in the current system.
13. **Open Enrollment Periods:** The NHC supports the amendment for a standardized open enrollment period across State Exchanges from November 1 to at least January 15, allowing more time for consumers to make informed

health coverage decisions, access assistance, reducing confusion, facilitating easier health coverage comparisons and transitions.

14. **Special Enrollment Periods (SEPs):** The NHC supports the proposed amendment aligning effective dates of coverage for SEPs across all Exchanges, simplifying insurance for consumers, especially those experiencing life events requiring special enrollment, by reducing coverage gaps and ensuring continuous, equitable health care.
15. **Network Adequacy Standards:** The NHC appreciates the proposed requirement for QHP issuers to report on telehealth services availability in State Exchanges and SBE-FPs effective from PY 2025, integrating telehealth into network adequacy standards, ensuring equitable health care access, especially for those with chronic conditions.
16. **EHB-Benchmark Plans, Drug Formularies and Copay Maximizers:** The NHC supports the proposed consolidation of State EHB-benchmark plan for PYs beginning on or after January 1, 2027, allowing States to select EHB-benchmark plans more effectively. Additionally, in the context of prescription drug formularies, this consolidation can play a crucial role in addressing concerns related to “copay maximizers.”
17. **Pharmacy and Therapeutics (P&T) Committee Standards:** The NHC supports the inclusion of a consumer representative in P&T committees starting January 1, 2026, ensuring patient perspectives are considered in formulary decisions, decisions with patient needs and preferences.
18. **Standardized Plan Options:** The NHC supports the updates to standardized plan options streamlining the insurance selection process, especially for those with chronic conditions, and continuing pre-deductible coverage for key benefits, emphasizing copayments over coinsurance.

The NHC offers the following detailed comments and recommendations in response to specific proposals in the 2025 NBPP.

Enhancing Public Engagement in Health Policy Decisions: Proposals for Section 1332 Waivers

The NHC supports the proposed modifications to the Section 1332 Waiver Public Notice Requirements in the 2025 NBPP as a positive development towards enhancing public engagement and inclusivity in health policy. The NHC views the allowance of virtual and hybrid formats for public hearings and post-award forums as a significant improvement in improving accessibility, facilitating broader public participation. This flexibility is particularly important in ensuring that diverse voices, including those of patients and patient advocacy groups, are heard in the health care policy-making process. The virtual format can be especially beneficial for individuals with chronic conditions,

disabilities, or those living in remote areas who may find in-person attendance challenging.^{1,2,3}

Standards Related to Reinsurance, Risk Corridors, and HHS Risk Adjustment

HHS Risk Adjustment (§ 153.320)

The NHC recommends that CMS conduct regular evaluations of the HHS-HCC risk score model to ensure it accurately reflects the costs associated with various chronic health conditions and maintains financial stability for issuers. It is essential to incorporate patient perspectives to ensure the model's sensitivity to the complexities of chronic conditions. This will aid in providing equitable compensation to issuers for covering enrollees with serious chronic conditions, thereby ensuring individuals with complex health needs have access to necessary care.

Streamlining the Establishment of State Health Insurance Exchanges

Ensuring a Smooth Transition to State-Run Health Insurance Marketplaces (§ 155.105(b))

The NHC supports the proposal to amend § 155.105(b), requiring states seeking to operate a State Exchange to first operate an SBE–FP for at least one PY as a thoughtful and strategic approach to health care marketplace management. The NHC recognizes that transitioning from a FFM to a State Exchange is a complex process that demands careful planning and execution. The requirement to operate as an SBE–FP for at least one PY serves as a crucial preparatory phase. This interim step allows states to cultivate necessary expertise and establish vital relationships with stakeholders, including consumers, consumer assisters, issuers, and other interested parties. Such preparation is key to ensuring a smooth and successful transition to a fully operational State Exchange.

Furthermore, the NHC especially appreciates the emphasis on maintaining access and consumer assistance services during this transition period. Ensuring that consumers continue to have access to a wide range of health care providers and receive adequate support in navigating the marketplace is paramount, ensuring access to high-quality health care and supporting patients in making informed health care decisions.

¹ Nowacki, K. (2023). *Virtual public engagement in agency rulemaking: Report to the Administrative Conference of the U.S.* Retrieved from <https://www.acus.gov/sites/default/files/documents/Final%20Report%20on%20Virtual%20Public%20Engagement%20in%20Agency%20Rulemaking.pdf>

² Administrative Conference of the U.S. (2023). *Recommendation 2023-2, virtual public engagement in agency rulemaking*, 88 Fed. Reg. 42680. Retrieved from <https://www.acus.gov/document/virtual-public-engagement-agency-rulemaking>

³ National Research Council. (2022). *Virtual public involvement: Lessons from the COVID-19 pandemic*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26827>

Clarifying Coverage Benefits in a State EHB-Benchmark Plan (§ 155.170(a)(2))

The NHC appreciates the proposed amendment to § 155.170(a)(2) in the 2025 NBPP, which clarifies that benefits covered in a State's EHB-benchmark plan are not considered in addition to EHB and therefore not subject to defrayal by the State starting in PY 2025. This clarification is a significant step forward in streamlining health care coverage and enhancing consumer protections.

Addressing the critical issue faced by States and consumers, the previous policy, which required States to defray the cost of benefits mandated after December 31, 2011, but not subjecting some benefits included in EHB-benchmark plans to defrayal requirements, led to confusion and operational challenges. The proposed clarification would reduce administrative burdens on States and ensure that mandated benefits included in the EHB benchmark plan, including preventative services, would receive EHB protections, such as nondiscrimination rules, limitations on cost sharing, and restrictions on annual or lifetime dollar limits. This is crucial for patients, particularly those with chronic conditions or complex health care needs, as it ensures access to essential health services with less financial burden. However, the NHC recognizes the complexities in state benefit mandate defrayal requirements and the need for transparency and appropriate oversight to ensure that states' updated benchmark plans are thorough and accurately reflect the health care needs of patients, particularly those with chronic conditions, and to prevent unintended consequences.

Improving Support and Guidance for Health Exchange Users (§ 155.205)

The NHC supports the proposal to require that all Exchanges provide consumers with access to live call center representatives during their published hours of operation. This ensures that consumers, especially those with chronic conditions or complex health needs, receive real-time assistance with their QHP applications, including understanding their options and eligibility APTC and CSR. In a study published in 2022 on telephone outreach increasing exchange enrollment in hard-to-reach populations, it was found that telephone calls from service center representatives increased individual enrollment in California by over 5% for adults aged 50 and older. Older adults are more likely to have chronic conditions than younger adults. Further, enrollment impacts were statistically significant for lower-income households (below 200% of the federal poverty level).⁴

Furthermore, the NHC recommends establishing uniform standards for English and Spanish language lines in call centers, along with implementing standards for accessible communication channels. This includes services like text-to-speech and speech-to-text, video relay and teletypewriter services for the deaf or hard of hearing, and provision of information in Braille or large print for those with visual impairments. In addition to these communication enhancements, there is a pressing need for

⁴ Myerson, R., Tilipman, N., Feher, A., Li, H., Yin, W., and Menashe, I. (2022). Personalized telephone insurance outreach increased health insurance take-up for hard-to-reach populations, but challenges remain. *Health Affairs*, 41(1). <https://doi.org/10.1377/hlthaff.2021.01000>

comprehensive education and support initiatives to assist all Health Exchange users, particularly those with chronic conditions or disabilities. We recommend the development of detailed educational material and resources, which should include easy-to-understand guides on health insurance concepts, benefits, and rights. These resources should be made available in multiple formats, including digital, print, and audio, to cater to diverse user needs. Furthermore, support services should extend to personalized assistance, where users can access expert guidance through one-on-one consultations, either virtually or in person. This approach will not only enhance user experience but also ensure that individuals are equipped with the knowledge and tools necessary to make informed decisions about their health care coverage. Additionally, ensuring that websites and digital content are designed following Web Content Accessibility Guidelines (WCAG) is crucial. These measures are essential to ensure equitable access to health care information for patients from diverse linguistic and ability backgrounds. Achieving parity in service standards through such inclusive communication strategies is not only a matter of fairness but also vital for effective communication. It ensures that all patients, regardless of their primary language or disability, have equal access to vital health care information and support, thereby bridging language barriers, promoting inclusivity, and ensuring that health care guidance is universally accessible and understandable.^{5,6,7}

Streamlining Health Insurance Enrollment with a Centralized Online Platform (§§ 155.205(b);155.302(a)(1)

The NHC supports the proposed amendments to §§ 155.205(b) and 155.302(a)(1) requiring Exchanges to operate a centralized eligibility and enrollment platform. They are essential for ensuring a streamlined and efficient process for consumers enrolling in QHPs. This is particularly beneficial for individuals with chronic conditions or complex health care needs, as it provides a single point of access for all necessary information and assistance. The NHC recognizes the importance of consistency and reliability in health insurance marketplaces, not only for the sake of administrative efficiency but also for ensuring that patients, particularly those with chronic conditions, have uninterrupted and clear access to health care coverage.

Furthermore, this platform can play a crucial role in enhancing transparency and accountability in the health care system. By having a central point for enrollment and eligibility, it becomes easier to monitor and evaluate the efficiency and effectiveness of the marketplace, ensuring that it meets the interests and needs of consumers. It reduces confusion and administrative burden for patients, who often face significant

⁵ Haldar, S., Pillai, D., and Artiga, S. (2023). Overview of health coverage and care for individuals with limited English proficiency (LEP). Retrieved from <https://www.kff.org/racial-equity-and-health-policy/issue-brief/overview-of-health-coverage-and-care-for-individuals-with-limited-english-proficiency/>

⁶ Monahan, C., Clark, J., and Stovicek, N. (2023). Uneven ground: Differences in language access across state-based marketplaces. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2023/sep/uneven-ground-differences-language-access-state-based-marketplaces>

⁷ Escontrías, O. (2022). Hispanic heritage month: The lucha (fight) continues for health equity in Hispanic/Latinx patients. Retrieved from <https://nationalhealthcouncil.org/blog/the-lucha-fight-continues-for-health-equity-in-hispanic-latinx-patients/>

challenges in navigating the health care system. A centralized system can ensure that all patients, irrespective of their state of residence, have equal access to the health care marketplace, thereby promoting equity and inclusivity in health care.

To further enhance this centralized platform, there is a vital need for comprehensive educational resources and support systems. We recommend the development and integration of user-friendly tutorials and guides within the platform, which would help users navigate the enrollment process and understand various health plan options and benefits. These resources should be designed to cater to a wide range of users, including those with limited health literacy or internet proficiency. Additionally, providing virtual assistance or helplines where users can receive personalized support and answers to their specific queries will greatly facilitate the enrollment process. This approach will not only streamline the enrollment experience but also ensure that individuals, especially those with chronic conditions or disabilities, are well-informed and supported throughout their decision-making process.

Uniform Guidelines for Web-Brokers in State Health Insurance Exchanges (§ 155.220)

The proposed amendment bolsters consumer protections by standardizing the display of QHP comparative information and disclaimer requirements. Such standardization is essential as web-brokers often operate across multiple Exchanges, and it is imperative that consumers receive a consistent level of information and service quality. These measures are key to reducing confusion and misinformation, thereby enhancing the consumer experience in the health insurance marketplace.⁸

The NHC appreciates the focus on operational readiness and compliance standards for web-brokers. This ensures that web-brokers are well-prepared and equipped to assist consumers, safeguarding their interests and data privacy. The NHC supports extending the FFE standard of conduct to State; this standard mandates that web-brokers provide accurate information without omission, avoid misleading marketing practices, and prevent discrimination. Ensuring that all consumers, regardless of their Exchange, receive equitable treatment is critical to promote an inclusive and non-discriminatory health care environment.

The proposal allows State Exchanges the flexibility to customize disclaimers and consumer educational information, balancing uniform federal standards with adaptability to meet state-specific needs. This flexibility is crucial for addressing the diverse needs of various populations, including those with specific health conditions.

The NHC values the emphasis on consumer education in these amendments. Ensuring that web-brokers transparently display crucial information about APTC, CSRs, and QHP options empowers consumers to make well-informed health care coverage decisions, empowering consumers through education and transparency in health care choices.

⁸ Ericson, K. and Starc, A. (2016). How product standardization affects choice: evidence from the Massachusetts health insurance Exchange. *Journal of Health Economics*, 50, 71-85. doi: 10.1016/j.jhealeco.2016.09.005

Finally, the NHC acknowledges the proposal's invitation for stakeholder engagement and feedback, particularly from States operating or aspiring to operate State Exchanges. This open dialogue fosters a collaborative approach to refining and enhancing the standards, ensuring they meet the needs of all stakeholders, including consumers, web-brokers, and State Exchanges.

Ensuring Non-Exchange Websites Align with Federal HealthCare.gov Updates (§ 155.221(b))

The NHC regards the proposal to align DE entity non-Exchange websites with changes on HealthCare.gov as a significant step forward. This alignment is essential for ensuring that consumers receive consistent information across different platforms, regardless of their chosen enrollment pathway. The requirement for DE entities to update their websites within a specific notice period set by HHS is particularly important. This measure ensures that enhancements aimed at improving the consumer experience or streamlining the enrollment process are implemented in a timely and efficient manner.

Extending this requirement to State Exchanges and their DE entities is a crucial step in creating a unified national framework for health insurance enrollment. This ensures that consumers in State Exchanges have the same access to information and user experience as those using federal platforms. The NHC recognizes the need for HHS to offer technical and operational support to DE entities, particularly when implementing complex changes. Such support is vital for maintaining the integrity of the system and ensuring that changes are executed correctly and effectively.

Finally, the NHC supports the proposed approach to enforcement and compliance. This ensures that DE entities adhere to the established standards, safeguarding consumer interests and maintaining the integrity of the enrollment process.

Setting Uniform Standards for DE Entities in State Health Exchanges (§ 155.221)

The NHC welcomes the initiative to amend § 155.221, aiming to extend certain HHS standards from Exchanges using the Federal platform to DE entities in State Exchanges. The NHC strongly supports the harmonization of DE entity standards across Federal and State Exchanges. This uniformity is crucial in ensuring that all consumers, irrespective of their state, benefit from equivalent protection and service quality. It also streamlines processes for DE entities operating across multiple states, promoting efficiency and reducing administrative complexities.

The NHC recognizes the challenges that State Exchanges might encounter in adopting these new standards, such as developing policies, updating existing standards, and possibly recruiting additional staff. We urge HHS to provide substantial technical support and resources to facilitate this transition for State Exchanges.

The NHC also suggests that HHS actively engage with a diverse array of stakeholders, including patient advocacy groups, health care providers, and insurers. This inclusive approach will ensure that the final regulations thoroughly address the needs of all parties involved in the health insurance enrollment ecosystem.

Improving the FTR Process (§ 155.305(f)(4))

The NHC commends the proposed amendments to § 155.305(f)(4) regarding the FTR process for its focus on enhancing consumer education and protection in health coverage and appreciates the consumer-centric approach, recognizing its potential to significantly ease the process for tax filers and promote continuous coverage, thereby supporting overall health and wellbeing. The NHC views the proposed annual notices as a vital step towards a more informed and safeguarded consumer base, especially for those with chronic conditions. To further enhance the effectiveness of the FTR process, there is an urgent need for targeted educational initiatives and support services. We recommend the implementation of a comprehensive education campaign that clearly explains the importance and mechanics of the FTR process. This campaign should include user-friendly guides, explanatory videos, and FAQs, aiming to demystify the process for consumers. Additionally, personalized support services, such as helplines or online chat assistance, should be available to help consumers navigate this process. These educational and support resources are crucial for ensuring that consumers, particularly those with chronic illnesses or limited health literacy, fully understand their responsibilities and the consequences of non-compliance in the FTR process. The NHC recommends personalized and direct communication strategies within these notices, ensuring they effectively convey the urgency and implications of FTR status and reach a diverse population with varying health literacy levels. Furthermore, the NHC encourages State Exchanges to embrace flexibility in implementing these changes, considering each Exchange's unique operational capabilities.

The NHC emphasizes the need for continuous evaluation and improvement of FTR communication strategies, incorporating feedback from affected consumers. Collaboration with various stakeholders, including patient advocacy groups and health care providers, is also recommended to develop effective tools for aiding tax filers in understanding and adhering to APTC reconciliation requirements. This holistic and collaborative approach is deemed essential for ensuring that the proposed changes yield positive outcomes for all involved parties, particularly those dependent on consistent health care coverage.

Simplifying Health Plan Enrollment for Individuals with Incarceration History (§ 155.315(e))

The NHC supports the proposed changes to § 155.315(e) as a commendable step towards streamlining the health insurance enrollment process for individuals with a history of incarceration, a population comprised of a significant number of people with

disabilities.^{9,10,11} The current verification process poses substantial challenges for formerly incarcerated individuals, who often encounter difficulties in securing necessary documentation and employment.¹² The proposed amendments could significantly ease access to health care for this vulnerable population, a crucial factor in their reintegration and overall health.^{13,14,15} In addition to streamlining the enrollment process, there is a significant need for targeted education and support specifically designed for individuals with a history of incarceration. We recommend the development of tailored educational materials and outreach programs that address the unique challenges and questions this population may face when enrolling in health plans. These resources should include clear, straightforward guides on eligibility, benefits, and how to navigate the health system. Furthermore, the provision of dedicated support services, such as counseling or assistance hotlines, could greatly aid in their transition, ensuring these individuals understand and can effectively utilize their health care benefits. These educational and support initiatives are vital for not only facilitating their enrollment but also for empowering them to take charge of their health care, contributing to successful reintegration into society. While supporting the relaxation of verification requirements, the NHC also emphasizes the importance of maintaining accurate data and program integrity. The proposed use of an HHS-approved alternative data source for verification should ensure that the data is current, precise, and administratively less burdensome, guaranteeing that only eligible individuals enroll in QHPs.

⁹ Russ, E., Puglisi, L., Eber, G., Morse, D., Taxman, F., Dupuis, M., Ashkin, E., and Ferguson, W. (2021). Prison and jail reentry and health. *Health Affairs*. doi: 10.1377/hpb20210928.343531

¹⁰ Mallik-Kane, K., Paddock, E., and Jannetta, J. (2018). *Health care after incarceration: How do formerly incarcerated men choose where and when to access physical and behavioral health services?* Retrieved from <https://www.urban.org/research/publication/health-care-after-incarceration>

¹¹ Apel, R. and Sweeten, G. (2014). The impact of incarceration on employment during the transition to adulthood. *Social Problems*, 57(3), 448-479. <https://doi.org/10.1525/sp.2010.57.3.448>

¹² Western, B. and Sirois, C. (2017). *Racial inequality in employment and earnings after incarceration*. Retrieved from https://scholar.harvard.edu/files/brucewestern/files/racial_inequality_in_employment_and_earnings_after_incarceration.pdf

¹³ Orozco, M. (2023). Health care coverage for the incarcerated population to reduce opioid-related relapse, overdose, and recidivism rates. Retrieved from <https://fas.org/publication/health-care-coverage-for-the-incarcerated-population-to-reduce-opioid-related-relapse-overdose-and-recidivism-rates/>

¹⁴ Jácome, E. (2021). How better access to mental health care can reduce crime. Retrieved from <https://siepr.stanford.edu/publications/policy-brief/how-better-access-mental-health-care-can-reduce-crime>

¹⁵ Russ, E., Puglisi, L., Eber, G., Morse, D., Taxman, F., Dupuis, M., Ashkin, E., and Ferguson, W. (2021). Prison and jail reentry and health. *Health Affairs*. doi: 10.1377/hpb20210928.343531

This initiative is likely to enhance health care access and potentially address inequities within the system.^{16,17} The NHC applauds the consumer-centric approach of allowing Exchanges to accept an applicant's attestation of incarceration status, significantly reducing administrative burdens on individuals, particularly those who have recently been released and are in need of health care services.¹⁸ Additionally, the NHC values the effort to reduce administrative complexities inherent in the current system, which largely depends on the Prisoner Update Processing System (PUPS), which has proven to be both administratively burdensome and costly; the proposed changes promise a more efficient allocation of resources while preserving the integrity of the program.¹⁹ Uninsurance declined significantly for recently incarcerated men after the ACA and the implementation of exchanges by removing the ties between employment and insurance coverage. Further, recently incarcerated individuals saw significant increases in diagnosed diabetes and other chronic conditions such as hypertension with access to state exchanges.²⁰

Streamlining Eligibility Checks for Affordable Health Insurance Programs (§ 155.320)

The NHC is supportive of initiatives aimed at streamlining access to health care, particularly for vulnerable groups. The proposed amendments to § 155.320, which facilitate the use of the Federal Data Services Hub (Hub) by State Exchanges and State Medicaid and CHIP agencies for accessing income data, enabling more efficient and accurate eligibility determinations, promises to enhance the overall process of accessing health care.²¹

The use of the Verify Current Income (VCI) Hub service could significantly improve the accuracy and integrity of the income verification process. Accurate income data is vital for determining eligibility for various insurance affordability programs, and the NHC

¹⁶ Sabol, W. and Johnson, T. (2022). *Justice system disparities: Black-White national imprisonment trends, 2000-2020*. Washington, DC: Council on Criminal Justice.

¹⁷ Rich, J., Chandler, R., Williams, B., Dumont, D., Wang, E., Taxman, F., Allen, S., Clarke, J., Grefinger, R., Wildeman, C., Osher, F., Rosenberg, S., Haney, C., Mauer, M., and Western, B. (2014). How health care reform can transform the health of criminal justice-involved individuals. *Health Affairs*, 33(3), 462-467. doi: 10.1377/hlthaff.2013.1133

¹⁸ Nellis, A. (2021). *The color of justice: Racial and ethnic disparity in state prisons: The sentencing project*. Retrieved from <https://www.sentencingproject.org/app/uploads/2022/08/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf>

¹⁹ Harvey, T., Busch, S., Lin, H., Aminawung, J., Puglisi, L., Shavit, S., and Wang, E. (2022). Cost savings of a primary care program for individuals recently released from prison: A propensity-matched study. *BMC Health Services Research*, 22(1). <https://doi.org/10.1186/s12913-022-07985-5>

²⁰ Gutierrez, C. and Pettit, B. (2020). Employment and health among recently incarcerated men before and after the Affordable Care Act (2009-2017). *American Journal of Public Health*, 110, S1, S123-S129. <https://doi.org/10.2105/AJPH.2019.305419>

²¹ Government Accountability Office. (2021). Federal low-income programs: Use of data to verify eligibility varies among selected programs and opportunities exist to promote additional use. Retrieved from <https://www.gao.gov/assets/gao-21-183.pdf>

supports efforts that contribute to the precision of these determinations, enhancing program integrity.

Alongside these technical improvements, there is a substantial need for educational resources and support to assist individuals in understanding their eligibility for different health insurance programs. We recommend the creation of clear, accessible guides and informational resources that explain the eligibility criteria, the application process, and the types of available programs. This should include user-friendly tools to help individuals estimate their eligibility based on their income and other factors. Additionally, establishing dedicated support services, such as help desks or counseling sessions, can provide personalized assistance, ensuring that individuals, especially those less familiar with the health insurance system, can navigate these processes effectively. This combination of education and support is essential for ensuring that individuals can fully benefit from the streamlined eligibility checks and access the health insurance coverage they need.

Simplifying Auto Re-Enrollment: Including Catastrophic Coverage (§ 155.335(j))p

The NHC views the proposed amendments to § 155.335(j) regarding the auto re-enrollment of individuals in catastrophic coverage as a significant step towards ensuring continuity and stability in health coverage. The inclusion of catastrophic plan enrollees in the auto re-enrollment process addresses a vital gap in the current system, ensuring that individuals who may not actively select a new QHP for the coming year are not left without coverage.

The NHC appreciates the proposal's intention to streamline the re-enrollment process for individuals currently enrolled in catastrophic coverage, particularly in instances where an issuer no longer offers a catastrophic plan for the subsequent year. This approach aligns with the Affordable Care Act (ACA)'s overarching goal of providing continuous, affordable health coverage to all Americans. Furthermore, the exclusion of catastrophic coverage from the re-enrollment hierarchy for enrollees currently in metal level plans is a prudent decision that respects the distinct nature of catastrophic plans and the specific needs of the enrollees in these plans.

However, the NHC urges careful consideration of the potential complexities and challenges that may arise from these changes. Specifically, there is a need for clear and accessible information for consumers transitioning from catastrophic coverage to metal level QHPs, especially regarding the application of APTC and understanding the different coverage benefits. The proposed amendment should be accompanied by robust consumer education and support mechanisms to assist enrollees in navigating these transitions.

Additionally, the NHC recommends HHS and State Exchanges engage in thorough consultations with all stakeholders, including patient organizations, to ensure that the auto re-enrollment process is implemented in a manner that minimizes confusion and administrative burdens, and is sensitive to the needs of diverse consumer populations. It is crucial that these processes are designed with a patient-centered approach, prioritizing the health and well-being of the enrollees.

Regarding the proposed amendment to § 155.400(e)(2) on premium payment deadline extensions, the NHC supports this change as it provides necessary flexibility to accommodate unforeseen circumstances, such as technical errors or natural disasters. This flexibility is essential for maintaining coverage continuity, particularly for vulnerable populations who may be disproportionately affected by such disruptions. It is important that these provisions are implemented in a manner that is transparent and fair to consumers, ensuring that individuals are not penalized for circumstances beyond their control.

Initial and Annual Open Enrollment Periods (§ 155.410)

The NHC supports the proposed amendment to § 155.410, which aims to standardize the open enrollment period for State Exchanges by requiring State Exchanges to adopt an open enrollment period starting on November 1 and ending no earlier than January 15. This proposal acknowledges the challenges and limitations inherent in a shorter enrollment period. Extending the open enrollment deadline to at least January 15 provides several significant benefits. Firstly, it allows consumers additional time to understand and react to updated plan cost information, which can be crucial in making informed decisions about their health coverage. This is particularly important given that plan costs and details are often not finalized or communicated until the end of the calendar year, leaving consumers with little time to adjust their choices in a shorter enrollment period.

Furthermore, a longer enrollment period benefits underserved communities, who often face more significant barriers to accessing health coverage.^{22,23,24,25} Extending the enrollment period provides these communities with more time to seek and receive assistance from Navigators, assisters, certified application counselors, agents, and brokers. This additional time is crucial in ensuring that all individuals, regardless of their socioeconomic status or health literacy levels, have equal opportunities to enroll in a health plan that best meets their needs.

²² Centers for Medicare & Medicaid Services. (2021). CMS extends open enrollment period and launches initiatives to expand health coverage access nationwide. Retrieved from <https://www.cms.gov/newsroom/press-releases/cms-extends-open-enrollment-period-and-launches-initiatives-expand-health-coverage-access-nationwide>

²³ Commonwealth Fund (2021). State-based outreach boosting enrollment uninsured. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/state-based-outreach-boosting-enrollment-uninsured>

²⁴ Office of the Assistant Secretary for Planning and Evaluation. (2021). Reaching the remaining uninsured: An evidence review on outreach & enrollment strategies. Retrieved from <https://aspe.hhs.gov/sites/default/files/documents/b7c9c6db8b17c6bfd6bb60b0f93746e/aspe-remaining-uninsured-outreach-enrollment.pdf>

²⁵ Patel, M., TerHaar, L., Smith, A., Tariq, M., Worthington, K., Hinton, J., and Lichtenstein, R. (2019). Knowledge of health insurance terms and the Affordable Care Act and in racially and ethnically diverse urban communities. *Journal of Immigrant and Minority Health*, 22, 456-466. <https://doi.org/10.1007/s10903-019-00924-3>

Consistency across State Exchanges in terms of open enrollment periods would also reduce consumer confusion. The variability in enrollment periods across different states can be a significant barrier to enrollment, as consumers may miss deadlines due to misunderstandings about when they can enroll.²⁶ A unified enrollment period across all Exchanges would simplify the process, making it easier for consumers to understand and act within the required timeframe.

While the NHC supports the objectives of the proposed amendment to § 155.410, we emphasize the importance of effectively communicating these changes to the public. Ensuring that consumers are well-informed about the new enrollment periods is crucial for the success of this initiative. The NHC recommends robust outreach and education campaigns, particularly targeted at underserved and vulnerable communities, to maximize the benefits of this proposed change.

Special Enrollment Periods

Effective Dates of Coverage (§ 155.420(b))

The NHC strongly supports the proposed amendments to § 155.420(b)(1) and (b)(3)(i) regarding the alignment of effective dates of coverage for SEPs across all Exchanges, including State Exchanges. This proposal is an important step toward simplifying the health insurance landscape for consumers, particularly those experiencing life-changing events that necessitate special enrollment, ensuring continuous and equitable health care. Furthermore, to maximize the effectiveness of these changes, there is a crucial need for comprehensive education and support tailored to SEPs. We recommend the development and dissemination of detailed informational resources that clearly explain the conditions and processes associated with SEPs. These resources should include guidelines on qualifying life events, necessary documentation, and deadlines. Additionally, providing dedicated support services, such as hotlines or online chat assistance, can help individuals navigate the complexities of SEPs. Such education and support are essential to ensure that consumers, especially those undergoing significant life changes, are fully aware of and can take advantage of their enrollment options during these critical periods.

The current variability in effective dates of coverage across different State Exchanges can lead to significant coverage gaps for consumers, especially those transitioning between Exchanges or from other types of insurance coverage.²⁷ For individuals who qualify for special enrollment due to events such as relocation, changes in household size, or loss of previous health insurance, the potential for a coverage gap poses a significant risk. This risk is particularly acute for those with ongoing health needs or chronic conditions, who cannot afford to be without coverage for an extended period.

²⁶ Commonwealth Fund (2021). State-based outreach boosting enrollment uninsured. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/state-based-outreach-boosting-enrollment-uninsured>

²⁷ Commonwealth Fund (2021). State-based outreach boosting enrollment uninsured. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/state-based-outreach-boosting-enrollment-uninsured>

However, while this proposal is a positive step, it is crucial to communicate these changes effectively to ensure that consumers are aware of and can take full advantage of the new effective date rules. The NHC recommends that Exchanges engage in robust outreach and education efforts, particularly targeting those who are most likely to use special enrollment periods. These efforts should include clear, accessible information about the changes and assistance for consumers navigating the enrollment process during these periods.

Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income at or Below 150 Percent of the Federal Poverty Level

The NHC strongly supports the proposed amendment to § 155.420(d)(16), which revises the parameters around the SEP for APTC-eligible individuals with a household income at or below 150 percent of the Federal Poverty Level (FPL). This proposal, which aims to make the "150 percent FPL SEP" a permanent option for Exchanges, is a crucial step in ensuring continuous and affordable health coverage for low-income populations. This is particularly relevant as it addresses the critical issue of health insurance coverage gaps that disproportionately affect lower-income individuals. This approach is especially important for those transitioning from Medicaid or CHIP coverage, who may face barriers in understanding and navigating their coverage options.

Setting Standards for Network Adequacy in Health Care Exchanges (§ 155.1050)

Proposal Regarding Reporting on Telehealth Services by QHPs

The NHC appreciates HHS' recognition that patients and consumers are more likely to seek telehealth services than before the COVID-19 pandemic and that they need better information to understand whether providers in a plans network offer telehealth services.^{28,29,30}

The collection of data on telehealth services is a positive step toward understanding the role and impact of telehealth in health care networks.³¹ This data will be instrumental in informing future development of telehealth standards and can potentially contribute to a more comprehensive understanding of network adequacy. The NHC believes that

²⁸ Blavin, F., Hill, I., Smith, L., and O'Brien, C. (2023). How adults with chronic health conditions experience telehealth. Retrieved from <https://www.urban.org/sites/default/files/2023-03/How%20Adults%20with%20Chronic%20Health%20Conditions%20Experience%20Telehealth.pdf>

²⁹ Williams, C. and Shang, D. (2023). Telehealth for chronic disease management among vulnerable populations. *Journal of Racial and Ethnic Health Disparities*, 13, 1-8. doi: 10.1007/s40615-023-01588-4

³⁰ Lawson, N., King, J., and Rontal, R. (2022). Disability and telehealth since the COVID-19 pandemic: Barriers, opportunities, and policy implications. Retrieved from https://disabilityhealth.medicine.umich.edu/sites/default/files/downloads/RRTC%20Telehealth_final2.pdf

³¹ Ahn, S., Corlete, S., and Lucia, K. (2016). Can telemedicine help address concerns with network adequacy? Opportunities and challenges in six states. Retrieved from <https://www.urban.org/sites/default/files/publication/79551/2000736-Can-Telemedicine-Help-Address-Concerns-with-Network-Adequacy-Opportunities-and-Challenges-in-Six-States.pdf>

detailed knowledge about telehealth services availability is vital for assessing the overall accessibility and responsiveness of health plan networks to the needs of patients, especially those who may face barriers to in-person health care services.

As the use of telehealth is evolving, it is important that HHS modernize the network adequacy framework to include telehealth and virtual care services, reflecting this evolution. Such improvements should involve consultations with patient organizations and other stakeholders to meet diverse patient needs, while carefully balancing the integration of telehealth with the continued necessity of in-person care. The NHC underscores that while telehealth has proven to be a valuable resource for many patients, particularly during the COVID-19 pandemic, it is not a universal solution for all health care needs. In-person care remains critical, especially for certain types of examinations, treatments, and for populations that may have difficulties accessing or using telehealth technologies.

Finally, there is also a pressing need for comprehensive education and support surrounding network adequacy standards and the use of telehealth services. We recommend the development of educational materials and resources that clearly explain how to evaluate the adequacy of networks, including the availability and accessibility of telehealth services, and how these services can meet their health care needs. Additionally, support mechanisms such as helplines or online platforms should be established to assist consumers in navigating network choices and resolving any concerns regarding access to care. This educational and support initiative is crucial to ensure that consumers are well-informed about their options and can make the best use of the health care services available through their plans.

ACA Standards for Health Insurance Issuers, Including Exchange-Related Standards

State Selection of EHB-Benchmark Plans for Plan Years Beginning on or After January 1, 2027 (§ 156.111)

The NHC supports the proposed consolidation of State EHB-benchmark plan options under § 156.111(a) for PYs beginning on or after January 1, 2027, recognizing its potential to simplify the process for States to select their EHB-benchmark plans and to respond more efficiently to health care needs, especially for those with chronic conditions and disabilities. The NHC also supports the proposed revisions to the scope of benefit requirements at § 156.111(b)(2) for PYs beginning on or after January 1, 2027. These revisions are aimed at ensuring that these plans provide a scope of benefits equal to typical employer plans in the State, thereby reducing both the time and resources required for States to update their EHB-benchmark plans. This change could encourage more frequent and relevant updates, reflecting evolving health care needs and standards.³²

However, there are financial barriers that States may face in making changes to their benchmark plans. This proposed change, while facilitating easier updates, could lead to

³² Centers for Medicare & Medicaid Services. (n.d.). Essential health benefits. Retrieved from <https://www.cms.gov/marketplace/resources/data/essential-health-benefits>

states providing more or less comprehensive coverage. Therefore, the NHC urges CMS to closely monitor changes to EHB benchmark plans if finalized, to ensure that the scope of benefits remains as high as it has been in previous years. It is crucial to ensure that these changes do not lead to a reduction in the comprehensiveness or quality of health care coverage. Flexibility in selecting EHB-benchmark plans must be balanced with maintaining robust coverage across all EHB categories, particularly those crucial for individuals with chronic illnesses, such as prescription drugs, mental health services, and rehabilitative and habilitative services.

We recommend that as these changes are implemented, there should be continuous stakeholder engagement, including with patient advocacy groups, health care providers, and insurers, to ensure that the needs of diverse populations, particularly those with chronic conditions, are adequately considered. Furthermore, ongoing monitoring and evaluation of the impact of these changes on the quality and comprehensiveness of health care coverage are essential. It is vital to ensure that the simplification of the selection process does not compromise the ability of States to provide comprehensive and responsive health care coverage to all individuals.

Prescription Drug Benefits (§ 156.122)

The NHC supports the proposal to transition from the USP Medicare Model Guidelines (USP MMG) to the USP Drug Classification (USP DC) for classifying drugs required to be covered as EHB under § 156.122(a)(1). This change marks a significant step towards enhancing drug benefits for individuals enrolled in plans subject to EHB requirements, particularly those with chronic conditions and special health care needs. The USP MMG, designed primarily for Medicare Part D, may not adequately address the health needs of a more diverse population covered under EHB plans, including younger individuals and women of reproductive age. USP's efforts in incorporating equity into the drug classification process through the USP DC, updated annually and encompassing a broader range of drug classes relevant to the general population, offers a more inclusive and comprehensive classification system, allowing for quicker incorporation of new medications and adjustments in classifications, thus reflecting the evolving landscape of pharmaceutical treatments. The increased opportunity for patient engagement in the annual review process of the USP DC is a significant advancement, allowing for regular updates and adjustments to align with changing health care needs. Transitioning to USP DC could address gaps in coverage for chronic conditions like obesity and infertility, which are currently inadequately covered under the USP MMG. Expanding drug categories to include treatments for these conditions aligns with the NHC's calls for patient-centered care, ensuring access to comprehensive treatment options.

In conjunction with these classification changes, there is a vital need for enhanced education and support to help consumers navigate the complexities of prescription drug benefits. We recommend the creation of detailed, easy-to-understand educational materials that explain the implications of the new drug classification system on coverage. These should include information on how to check if specific medications are covered, the process for obtaining required medications, and understanding any associated costs. Additionally, establishing dedicated support lines or online assistance can provide direct help to consumers who have questions or face difficulties in

accessing their medications. This approach will ensure that consumers, particularly those with chronic conditions dependent on regular medications, are well-informed and supported in managing their prescription drug needs.

However, the NHC is cognizant of the challenges and potential administrative burdens this transition may pose for issuers, including the need to update formulary systems and potential impacts on premiums. It is essential to balance the benefits of a more inclusive drug classification system with the practicalities of implementation. We recommend a thoughtful approach complemented by robust education, outreach, and technical assistance programs, to mitigate potential disruptions in patient care and undue financial impacts. Moreover, we advocate for the inclusion of patient and consumer perspectives in the review and update process of USP DC. Regular consultation with patients, caregivers, and patient advocacy groups can ensure that the classification system remains responsive to the needs of those it serves. This approach aligns with the principle of patient-centeredness, a core value of the NHC.

The NHC also supports the proposal to amend § 156.122 to “codify that prescription drugs in excess of those covered by a State’s EHB-benchmark plan are considered EHB.” Under the ACA’s EHB rules for prescription drug coverage, individual and small group plans must cover either at least one drug in each drug category or class or the same number of drugs per category and class as the state’s EHB-benchmark plan, whichever is higher. Plans have always been free to cover more drugs than these minimum standards. However, some plans or Pharmacy Benefit Managers categorize additional drugs they cover beyond these minimum standards as “non-EHB.” This categorization may allow plans to treat these drugs as if they are not subject to EHB protections, including the requirement that all cost-sharing, whether paid directly by the patient or by a third party, for these drugs counts toward an individual patient’s cost-sharing limits and the prohibition of applying annual and lifetime limits for these drugs. Further, it may create confusion for individuals taking multiple medications, some of which will be subject to EHB protections and others not. This amendment will ensure that prescription drugs covered beyond the state’s EHB-benchmark are acknowledged as EHBs granting them additional protection, countering the use of “copay maximizers” and confirming these additional drugs contribute towards their deductible and annual

cost-sharing limits. This is particularly crucial for patients with chronic conditions or rare diseases, who often rely on multiple or specialized medications.^{33,34,35,36,37}

However, we also urge CMS to monitor any unintended consequences of this policy, such as a potential decrease in the breadth of formularies beyond the EHB benchmark.

Pharmacy and Therapeutics Committee Standards

The NHC strongly supports the proposed amendment to § 156.122, which mandates the inclusion of a consumer representative in Pharmacy and Therapeutics (P&T) committees for PYs beginning on or after January 1, 2026. The inclusion of a consumer representative on P&T committees is a crucial step towards ensuring that formulary decisions consider the patient perspective. This representative can provide invaluable insights into the real-world impact of medications on patients, including side effects, ease of use, and quality-of-life outcomes that may not be immediately apparent from clinical data alone. Their presence will help ensure that formulary decisions are not only clinically sound but also align with the needs and preferences of the patients who will ultimately use these medications.

Furthermore, the requirement for consumer representatives to have affiliations with, or active participation in, consumer or community-based organizations ensures that these representatives are well-informed, engaged in patient advocacy, and can convey the broader patient perspective – including challenges and concerns faced by diverse patient populations. The NHC recommends CMS collaborate with patient organizations and other stakeholders to develop additional standards to appropriately safeguard against potential conflicts of interest. Additionally, we encourage CMS to review resources from the NHC on best practices for integrating the patient voice into health care decision making and to ensure that P&T committees are able to effectively engage with and facilitate patient participation.³⁸

³³ Assistant Secretary for Planning and Evaluation. (2022). Prescription drug affordability among Medicare beneficiaries. Retrieved from <https://aspe.hhs.gov/reports/medicare-prescription-drugs>

³⁴ Becker, N., Scott, J., Moniz, M., Carlton, E., and Ayanian, J. (2022). Association of chronic disease with patient financial outcomes among commercially insured adults. *JAMA Internal Medicine*, 182(10). 1044-1051. doi: 10.1001/jamainternmed.2022.3687

³⁵ Hajat, C., Siegal, Y., and Adler-Waxman, A. (2021). Clustering and healthcare costs with multiple chronic conditions in a US study. *Public Health*, 8. <https://doi.org/10.3389/fpubh.2020.607528>

³⁶ Cubanski, J., Koma, W., Damico, A., and Neuman, T. (2019). How much do Medicare beneficiaries spend out of pocket on health care? Retrieved from <https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/>

³⁷ Sambamoorthi, U., Tan, X., and Deb, A. (2015). Multiple chronic conditions and healthcare costs among adults. *Expert Review of Pharmacoeconomics & Outcomes Research*, 15(5), 823-832. doi: 10.1586/14737167.2015.1091730

³⁸ National Health Council. (n.d.). Patient engagement: Capturing and including the patient voice. Retrieved from <https://nationalhealthcouncil.org/issue/patient-engagement/>

We also suggest that the number of consumer representatives on a P&T committee should be proportional to the size of the committee, ensuring adequate patient representation. One representative may not sufficiently capture the diversity of patient experiences and needs, especially in larger committees overseeing a wide range of medications. Regarding the proposed timeline for implementation, we acknowledge the need for a reasonable period for recruitment, selection, and training of consumer representatives. We suggest a phased implementation approach, allowing enough time for organizations to adapt to this significant change.

Regulations Regarding Standardized Health Plan Options (§ 156.201)

The NHC views the proposed updates to the standardized plan options for PY 2025 under § 156.201 as essential for ensuring that patients have access to comprehensive coverage and maintaining consistency with the approach established in the 2023 and 2024 Payment Notices.^{39,40} This is a significant step towards enhancing the health care enrollment experience, improving access to health care services, and promoting equity in the health insurance marketplace. We encourage HHS to continue refining these options to meet the evolving needs of all consumers, particularly those with chronic health conditions.

The NHC appreciates HHS's efforts to streamline the health insurance selection process through standardized plan options. This approach is particularly beneficial for consumers, including those with chronic conditions, as it simplifies the comparison of plans by minimizing variables. Consumers can focus on critical factors like networks, formularies, and premiums, making informed decisions more accessible. One of the notable aspects of the proposed standardized plans is the continuation of enhanced pre-deductible coverage for several benefit categories across all metal levels. The emphasis on copayments over coinsurance rates for numerous benefit categories is another positive aspect, as it helps to mitigate the risk of unexpected financial costs for consumers. Acknowledging the complexity of coinsurance and its impact on consumers' ability to predict out-of-pocket costs is crucial. Coinsurance often leads to confusion, particularly for those requiring frequent health care services. The NHC recommends the inclusion of standardized plans with affordable copayments on the FFE, as this approach would significantly enhance consumer satisfaction. By providing clearer and more predictable health care expenses, these plans could substantially reduce financial unpredictability for patients, improving health care accessibility and reducing barriers for those with chronic health conditions.

The NHC also supports consistency in plan options; consistency ensures that individuals enrolled in these plans do not face unexpected changes in cost-sharing, thereby protecting them from financial hardship. Moreover, the NHC values the proposal's potential impact on health equity. By ensuring easy access to essential services without meeting deductibles and providing clear cost-sharing structures, these

³⁹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024, 88 Fed. Reg. 08368 (April 27, 2023) (to be codified at specified parts of 45 C.F.R.).

⁴⁰ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 09438 (May 6, 2022) (to be codified at specified parts of 45 C.F.R.).

standardized plans could play a significant role in advancing health equity. The NHC urges HHS to consider the implications of these updates on State Exchanges, especially those transitioning from FFEs or SBE-FPs to State Exchanges, encouraging uniformity and ease of access for consumers across different states.

Regulatory Constraints on Non-Standardized Health Plan Option (§ 156.202)

The NHC has assessed the proposed amendments to § 156.202 regarding non-standardized plan option limits for PY 2025 and beyond. The NHC, representing the interests of patients, particularly those with chronic conditions, views the proposal with concern, particularly regarding the proposed exceptions process allowing issuers to offer additional non-standardized plan options beyond the limit of two per product network type, metal level, and service area.

While the NHC recognizes the potential benefits of plan options tailored to meet the needs of consumers with specific chronic conditions, there is a significant concern that the proposed exceptions process may lead away from the goal of decreasing non-standardized plans. The move to reduce the number of non-standardized plan options from four in PY 2024 to two in PY 2025 was welcomed as it aimed to reduce plan proliferation, which can be overwhelming for consumers, especially those with chronic conditions. The proposed exceptions process, however, risks reversing this progress by potentially increasing the number of plan options, thus complicating the plan selection process.

The NHC is concerned that allowing an unlimited number of exceptions based on specific design features for chronic conditions could lead to a marketplace cluttered with an excessive variety of plans. This complexity may not only confuse consumers but also make it more challenging for them to identify plans best suited to their health needs. While the intention to cater to specific health needs is commendable, the execution via numerous exceptions could inadvertently lead to a more convoluted and less consumer-friendly market.

Moreover, the NHC believes that the criteria set for exceptions may not sufficiently safeguard against the misuse of this process. The requirement that additional non-standardized plans should have cost-sharing for chronic conditions at least 25% lower than other plans is specific but may not be adequate to ensure that these plans are genuinely beneficial and not merely a means to introduce more plan options into the market.

Furthermore, the NHC urges HHS to consider the impact of these proposed changes on state exchanges and the overall health insurance ecosystem. While catering to specific needs is important, maintaining a balance between specialized and generalized plan options is crucial for a functional and efficient market. There is a risk that the proposed exceptions could lead to a market imbalance, disproportionately favoring certain conditions over others, and potentially overlooking the broader needs of the patient community.

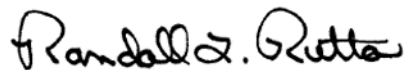
The NHC suggests that HHS reconsider the approach of allowing unlimited exceptions to the limit on non-standardized plan options. Instead, a more balanced approach,

possibly involving a cap on the number of exceptions or stricter criteria for exception eligibility, could be explored. This would help maintain a simplified, consumer-friendly marketplace while still providing necessary specialized options for those with specific chronic and high-cost conditions. The NHC emphasizes the importance of a health insurance market that is accessible, understandable, and equitable for all consumers, particularly those managing chronic illnesses.

Conclusion

The NHC thanks CMS for the opportunity to provide input on this important proposed rule. 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 comments 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