NATIONAL HEALTH COUNCIL

November 12, 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 2026; and Basic Health Program; CMS-9888-P, RIN 0938-AV41

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the 2026 Notice of Benefit and Payment Parameters (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 more than 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.

General Support for CMS Proposals

The NHC commends CMS for its ongoing commitment to advancing health equity, improving access to care, ensuring program integrity, and maintaining affordability through Marketplace coverage. We appreciate many of the proposed changes in the 2026 NBPP, and our comments are focused on specific provisions where we believe CMS can further strengthen patient-centered health care.

Key Patient-Centered Priorities

Health Equity and Access to Care

The NHC supports CMS' ongoing efforts to advance health equity through the policies outlined in the 2026 NBPP. Achieving equitable access to care is essential for improving health outcomes, particularly for individuals from underserved communities, rural areas, and those managing chronic health conditions. The proposed rule offers several

opportunities to reduce disparities, but more can be done to address the unique challenges faced by vulnerable populations.

Telehealth and Health Equity. One of the most significant advancements in promoting health equity is the expanded use of telehealth services. Telehealth has proven to be a vital tool in improving access to care for individuals in rural and underserved areas, as well as for patients managing chronic conditions. The COVID-19 pandemic demonstrated the critical role telehealth can play in mitigating barriers to care, and we believe it should continue to be a cornerstone of patient care.

We recommend, in future rulemaking, that CMS require Qualified Health Plans (QHPs) to report on the availability and utilization of telehealth services, broken down by specialty, geographic location, and demographic factors such as income and race/ethnicity. This data will help CMS and stakeholders assess whether telehealth is effectively addressing health disparities and highlight areas where additional telehealth services or in-person care may be needed to close gaps in access.

While telehealth is a powerful tool for improving access, it is not a substitute for all types of care. CMS should ensure that patients continue to have access to in-person services, particularly for diagnostic tests, physical exams, and other care that cannot be delivered virtually. We also recommend that CMS ensure that telehealth platforms are fully compliant with Americans with Disabilities Act (ADA) standards and that they offer language interpretation services to meet the needs of individuals with disabilities or language barriers.

Addressing Barriers to Access for Underserved Populations. Beyond telehealth, the NHC urges CMS to focus on other structural barriers to care that disproportionately affect underserved populations. For instance, individuals in rural areas, communities of color, and low-income households often face challenges in accessing high-quality care due to a lack of available providers, transportation difficulties, and financial barriers. To address these disparities, we recommend that CMS prioritize policies that expand provider networks in underserved areas and provide additional resources to support care coordination for these populations. Additionally, we encourage CMS to explore ways to incentivize providers to practice in high-need areas through payment adjustments or other support mechanisms.

Data Collection to Promote Health Equity. The NHC encourages CMS to expand its efforts to incorporate social drivers of health (SDOH) into data collection and risk adjustment models. By integrating factors such as income, education, and geographic location into risk scores, CMS can ensure that plans serving high-risk populations are adequately compensated and that disparities are more effectively addressed. Accurate data on SDOH will also provide a clearer picture of where inequities exist and help guide targeted interventions to improve care for underserved populations.

Equitable Access to Medications. The NHC supports CMS' commitment to ensuring equitable access to affordable medications through the proposed Affiliated Cost Factor (ACF), which is critical for addressing adverse selection risks associated with high-cost drugs such as HIV pre-exposure prophylaxis (PrEP), multiple sclerosis

medications, oncology drugs, rare disease therapies, and rheumatoid arthritis and autoimmune therapies. PrEP in particular is a high-value public health intervention with costs that are not effectively captured by typical risk adjustment models, as its usage is not uniformly tied to specific age, sex, or diagnostic factors. Recognizing PrEP as a preventive service rather than as indicative of an active medical condition, as HHS proposes, could help address the current risk selection seen in the market. Including both brand-name and generic versions of essential medications within the ACF will further reduce financial burdens on patients who rely on these treatments. By incorporating generics alongside brand-name medications, CMS can foster cost-effective care and help prevent unnecessary financial strain on both patients and payers.

Furthermore, the NHC recommends CMS ensure that the overall effect of manufacturer rebates is considered within the ACF model, particularly as they impact patient out-of-pocket expenses, while balancing transparency with respect to cost-sharing structures to promote equitable patient access to medications. Given the increasing reliance on rebates in managing drug costs, transparency in how these rebates affect cost-sharing is crucial to maintaining fairness in the pricing and accessibility of medications. Clear guidance on the treatment of rebates within the ACF will help avoid distortions in pricing and prevent patients from bearing disproportionate costs.

We also recommend that CMS engage stakeholders, including patient organizations, payers, and health care providers, in refining the ACF model. Stakeholder collaboration will ensure that the ACF accurately reflects real-world costs and usage patterns for medications. This approach will help ensure that the ACF supports the broad coverage of necessary therapies without inadvertently creating barriers to access.

Copay Assistance and Drug Coverage in Large Group Plans

Accumulator Adjustment Programs and Cost Sharing. The NHC is deeply concerned about the continued use of Accumulator Adjustment Programs (AAPs) and other discriminatory cost-shifting tactics such as copay maximizers and alternative funding programs (AFPs) which circumvent the cost-sharing protections afforded to patients under the Affordable Care Act (ACA). AAPs prevent manufacturer copay assistance from counting toward a patient's deductible or out-of-pocket maximums, directly contradicting the ACA's intent to protect patients from excessive financial burdens. By excluding copay assistance, AAPs increase the financial strain on patients, especially those with chronic conditions requiring high-cost medications. Recent data highlights the significant impact these programs have on patients. In 2023, patient out-of-pocket costs in the commercial market increased by $5 billion, reflecting an 11 percent rise over the past five years.[1] Patients subject to AAPs, copay maximizers, and AFPs often pay considerably more than those with copay-only arrangements, incurring out-of-pocket costs that are, on average, 500 percent higher and facing a fourfold

[1] IQVIA. *Use of Medicines in the U.S.* May 2024. https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf.

increase in treatment abandonment for brand-name medications.[2] High out-of-pocket costs also affect medication adherence; 69 percent of commercially insured patients choose not to initiate therapy when their out-of-pocket cost exceeds $250, highlighting how these burdens contribute to prescription nonadherence and adverse health outcomes.[3] By excluding copay assistance, AAPs and similar programs create significant financial strain, especially on patients with chronic conditions reliant on high-cost treatments. The NHC urges CMS to address these practices by enforcing regulations that uphold the ACA's core protections and ensure that programs do not unfairly shift costs onto patients.

These practices continue to undermine the cost-sharing protections established by the ACA, disproportionately impacting patients with chronic conditions who depend on high-cost, life-saving treatments. Accumulator Adjustment Programs (AAPs) and similar practices prevent manufacturer copay assistance from counting toward a patient's deductible or out-of-pocket maximum, effectively shifting significant costs back to patients and increasing their financial burden. While legal challenges have raised concerns about such practices, the administration has yet to issue definitive regulations to address them. We urge CMS to safeguard ACA protections by implementing rules that explicitly prohibit AAPs, ensuring that patients receive the full benefit of cost-sharing assistance and are not unfairly burdened by excessive out-of-pocket costs.

Notably, cost-sharing assistance is rarely applied when generic alternatives are available, as data from CMS' 2020 NBPP solution, which clarifies how copay assistance could be applied, demonstrates.[4] This policy effectively improved access to necessary medications without raising costs. Although several states and insurance commissioners have taken steps to enforce the 2020 NBPP, federal action from HHS is now needed to ensure that all patients benefit from the inclusion of manufacturer assistance in cost-sharing limits.

The NHC urges CMS to swiftly issue these regulations, reinforcing the ACA's consumer protections and ensuring that manufacturer copay assistance is counted toward a patient's cost-sharing obligations, thereby alleviating the financial burden on patients who depend on high-cost treatments.

Extension of Essential Health Benefits (EHB) to Large Group Plans. CMS has yet to finalize regulations that would extend essential health benefits (EHB) requirements to large group and self-funded plans, despite previous expectations for

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[2] 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.

[3] Devane, K., Harris, K., and Kelly, K. Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption. IQVIA, 2018. https://www.iqvia.com/-/media/iqvia/pdfs/us/us-location-site/market-access/patient-affordability-part-two---implications-for-patient-behavior-and-therapy-consumption.pdf.

[4] IQVIA. *An Evaluation of Co-Pay Card Utilization in Brands After Generic Competitor Launch*. IQVIA, January 11, 2022. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization.

such an action.[5] Without this extension, insurers in these plans can continue to categorize certain drugs as "non-essential," leaving patients without critical protections for accessing necessary medications. This categorization also enables cost-shifting mechanisms like copay maximizers, which can inflate patient cost-sharing amounts to the maximum value of available assistance programs—often reaching thousands of dollars per prescription. As a result, patients may face substantial out-of-pocket costs unless they enroll in a patient assistance program, creating significant financial barriers to accessing essential medications. While extending EHB requirements to large group and self-funded plans could help address some of these cost-sharing challenges, it may not completely eliminate discriminatory practices. To better protect patients, we encourage CMS to consider finalizing regulations that address cost-sharing limitations on covered drugs in large group plans. Such regulations would help curb cost-shifting tactics, including copay maximizers and alternative funding programs, while preserving flexibility for large group plans regarding the scope of essential health benefits they choose to cover. By ensuring fair cost-sharing protections, CMS can enhance access to necessary medications without imposing burdensome requirements. We urge CMS to finalize these regulations, expanding EHB protections in a way that supports affordable access to essential medications without enabling discriminatory cost-sharing practices.

Medical Debt Relief

The NHC supports CMS' proposal to allow Certified Application Counselors (CACs) at hospitals and other providers to assist patients in enrolling in programs aimed at alleviating medical debt. Given the significant role that hospitals and providers play in the accumulation of medical debt, this proposal represents an important step toward advancing health equity. To further strengthen this initiative, we recommend that CMS implement enhanced oversight to ensure that patients who are eligible for charitable care or other financial assistance programs are not improperly sent to collections. Such safeguards are critical to protecting patients from unnecessary financial burdens and ensuring equitable access to care for vulnerable populations.

Program Integrity and Consumer Protections

Preventing Fraudulent Enrollments & Program Integrity Measures

The NHC supports CMS' ongoing efforts to strengthen program integrity by preventing fraudulent enrollments in the health insurance Marketplace. Ensuring that consumers have access to accurate, trustworthy information and that their enrollments are legitimate is essential to maintaining the overall credibility and functionality of the Marketplace. Fraudulent enrollments not only undermine consumer trust but also increase administrative burdens and costs for insurers, ultimately affecting patients by driving up premiums or reducing plan offerings. Furthermore, ensuring that consumers are able to enroll in plans that best meet their health care needs is a crucial part of this

[5] Centers for Medicare & Medicaid Services (CMS). "*Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025.*" Federal Register 89, no. 72 (April 15, 2024): 22010-22115. https://www.federalregister.gov/documents/2024/04/15/2024-07274/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025.

integrity effort. When patients with chronic conditions understand their coverage options fully and select plans that provide the necessary services, they are more likely to receive continuous, appropriate care. This can lead to better management of their conditions, helping to reduce costs by avoiding emergency department visits and inpatient admissions. By fostering informed plan selection, CMS can support patients in accessing the right coverage while promoting a more sustainable Marketplace for everyone.

We commend CMS for its proposed updates to the Model Consent Form and the introduction of standardized scripts for brokers, agents, and web-brokers. These tools will enhance consumer protection by ensuring that individuals submitting applications review and confirm the accuracy of their information. Requiring brokers, agents, and web-brokers to follow clear, uniform guidelines in verifying consent will help reduce errors and prevent fraudulent enrollments, especially in cases where consumers may not fully understand the information being submitted on their behalf. This not only safeguards the integrity of the enrollment process but also reinforces transparency and accountability within the Marketplace.

The NHC believes that the success of these measures relies on ensuring that they are implemented effectively across all stakeholders involved in enrollment, including state exchanges, brokers, and insurers. To further enhance these efforts, we encourage CMS to establish clear oversight and monitoring mechanisms to ensure compliance with the updated Model Consent Form and standardized scripts. This would provide an additional layer of protection for consumers while helping to identify and address any patterns of non-compliance or fraudulent activity in real time.

In addition to these updates, the NHC strongly supports CMS' proposal to publish state marketplace operational reporting through the State Marketplace Annual Reporting Tool. This initiative aligns with the NHC's long-standing advocacy for increased transparency and accountability in the health care system. By making operational data from state marketplaces publicly available, CMS will empower consumers, advocates, and policymakers to assess the performance and efficiency of state-run exchanges. This transparency will also foster greater competition among state exchanges, incentivizing improvements in consumer experience, enrollment processes, and overall plan offerings.

To ensure the accessibility of this information, we recommend that CMS take additional steps to present the operational data in a user-friendly format. This includes reviewing the published information through plain language experts to ensure it is understandable for the general public. Moreover, the data should be made fully compliant with ADA accessibility standards, allowing individuals with disabilities to access and interpret the information without barriers. Presenting this data in a clear and accessible manner will help maximize its value to all stakeholders and ensure that it can be used to inform meaningful policy and operational decisions.

More Flexibility on Premium Payment Thresholds

The NHC supports CMS' proposal to introduce additional flexibility around premium payment thresholds, a critical step toward ensuring that patients, particularly those with

chronic conditions, do not lose coverage due to minor payment discrepancies. This proposal, which allows insurers greater leeway in keeping patients enrolled when they owe nominal amounts on their premiums, is especially important for individuals who require consistent access to care and medications to manage ongoing health conditions. Flexibility in premium payment thresholds can prevent unnecessary gaps in coverage that could have serious consequences for patients with complex medical needs.

We believe that while the proposed flexibility for premium payments is a positive development, it could be further strengthened by extending this flexibility to binder payments. Binder payments, which are the initial payments required to activate health insurance coverage, can pose a significant challenge for patients who may be facing financial instability at the time of enrollment. Extending the flexibility to binder payments would ensure that minor shortfalls in initial payments do not result in coverage delays or denials, particularly for vulnerable populations who are at risk of being uninsured or underinsured. By preventing interruptions in coverage from the outset, CMS can help ensure that patients receive the care they need without delay, minimizing the administrative burden of reactivating coverage or navigating special enrollment periods.

Additionally, we recommend that CMS establish clear guidelines for insurers regarding how this flexibility will be applied uniformly across all plans. Standardizing the application of premium payment thresholds would prevent disparities in how insurers implement the flexibility and ensure that patients across all regions and insurance plans are protected from losing coverage due to minor payment discrepancies. This uniformity will also promote equity within the Marketplace, ensuring that all patients—regardless of their insurer—have the same protections against coverage loss due to nominal premium underpayments.

Furthermore, to ensure that these measures are transparent and accessible to consumers, we encourage CMS to require insurers to clearly communicate any available payment threshold options to their members. Insurers should proactively inform consumers about the premium payment flexibility, including how it applies to both ongoing premium payments and binder payments, so that patients can make informed decisions about their coverage and payment responsibilities. Enhanced communication will empower consumers, reduce confusion, and help prevent unintentional coverage loss due to misunderstandings about payment policies.

Standardized Benefit Designs

The NHC recognizes the significance of CMS' proposed updates to standardized benefit requirements, particularly the reintroduction of the meaningful difference standard aimed at reducing choice overload. As more patients transition from Medicaid to Exchange coverage, the ability to make informed decisions about health plans is increasingly vital. Many of these individuals, especially those transitioning for the first time, may be unfamiliar with how to navigate the complexities of the health insurance Marketplace. Ensuring that plan options are clear and meaningfully differentiated will help prevent confusion and promote better decision-making among consumers.

The reintroduction of the meaningful difference standard is a critical step toward simplifying plan selection. However, we encourage CMS to continue refining these rules to ensure that standardized plans are designed in a way that helps patients easily identify the coverage options that best meet both their health and financial needs. For patients with chronic conditions or complex health care requirements, access to the right plan is crucial to maintaining continuity of care, minimizing out-of-pocket expenses, and preventing gaps in necessary treatments or medications. Standardized plans promote predictable and affordable cost-sharing on essential care by incorporating copayments instead of coinsurance and covering certain services pre-deductible, thereby enhancing access to necessary care for patients.

In addition to refining the meaningful difference standard, we urge CMS to carefully monitor the impact of these changes on consumer experience, particularly with regard to the distinction between adult and pediatric dental benefits. Differentiating these benefits while limiting the number of non-standardized plans is an important component of reducing complexity, but it also introduces potential challenges for consumers. CMS should ensure that this distinction does not inadvertently increase the complexity of plan choices, especially for families that require both adult and pediatric dental coverage. Clear communication and transparent presentation of these benefit distinctions will be necessary to help families understand their options and make informed decisions.

Moreover, as part of its ongoing effort to standardize benefit designs, we recommend that CMS work closely with stakeholders, including patient advocacy groups, to continually assess the real-world impact of these changes. Regular feedback from consumers and patient organizations will help ensure that standardized plans are meeting the needs of diverse populations, particularly those with chronic or rare conditions that may require specialized care. By engaging with stakeholders throughout the implementation process, CMS can adapt and improve standardized benefit designs based on the lived experiences of patients navigating the Marketplace.

Additionally, we recommend that CMS provide educational resources for consumers, including plain language explanations and decision support tools, to further aid in plan selection. Given the increasing complexity of health care decisions, particularly for those transitioning from Medicaid or those with limited experience navigating private insurance, access to clear and accessible information is essential for empowering patients to choose the plan that best suits their needs.

Quality and Network Standards

Quality Improvement Strategy (QIS)

The NHC supports CMS' proposal to publicly release aggregated, summary-level QIS data on an annual basis. Transparency in QIS activities is essential for promoting accountability and fostering innovation in patient care. However, we believe certain adjustments could enhance the impact and accessibility of this data.

First, we recommend that CMS release the aggregated QIS data before proposed rates for the upcoming benefit year are due. This would allow issuers and stakeholders to incorporate QIS performance insights into their planning and ensure that proposed rates

reflect ongoing efforts to improve quality and patient outcomes. Timely release of this information will ensure that it is fully considered during rate-setting processes, benefiting both issuers and patients.

Additionally, to enhance the public presentation of QIS data, we suggest that CMS ensure the information is reviewed by plain language experts to guarantee clarity and ease of understanding for the general public. Making this data accessible to a wider audience will empower patients and stakeholders to make informed decisions. Furthermore, we urge CMS to comply with ADA accessibility standards when presenting this data, ensuring that individuals with disabilities can access and understand the information without barriers.

Finally, while we support the release of summary-level data, we encourage CMS to create a repository of best practices based on QIS submissions. This would enable issuers to learn from one another and implement strategies that have been proven effective in improving patient outcomes and reducing health disparities. By sharing insights across the health care ecosystem, CMS can help promote continuous improvement in the quality of care.

By addressing these points, CMS can ensure that QIS data is not only transparent but also timely, accessible, and actionable for both issuers and patients.

Technical Considerations for Insurers

Medical Loss Ratio (MLR) and Definition of Qualifying Issuer

CMS' proposed adjustments to the Medical Loss Ratio (MLR) to allow "qualifying issuers"—those with risk adjustment payments exceeding 50 percent of their earned premiums—to shift these receipts to the MLR denominator rather than the numerator present both potential benefits and drawbacks, and the NHC recommends that CMS carefully weigh these impacts before finalizing the policy.

This adjustment could ease financial pressures on plans heavily involved in risk adjustment, potentially benefiting patients with chronic conditions by stabilizing plans that are more likely to serve high-cost populations. Increased flexibility for qualifying issuers may help reduce the risk of significant premium increases, prevent plan withdrawals, and promote more consistent access to care for patients who rely on specialized treatments. By helping maintain plan stability, this adjustment could also support broader, more comprehensive coverage options for patients managing chronic conditions.

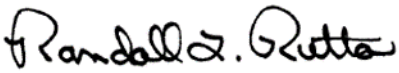
However, this policy change could lead to reduced rebates and potentially higher premiums for enrollees, imposing additional costs on patients who already face high out-of-pocket expenses. Limiting this flexibility to a subset of issuers also risks creating market imbalances, potentially leading to higher costs or fewer coverage options for other plans. Additionally, there is a concern that this change could unintentionally incentivize cost-cutting in ways that reduce benefit quality, affecting patients' access to necessary care.

To protect patient access to affordable and comprehensive care, the NHC recommends that if CMS decides to move forward with the proposed adjustment, it carefully monitor the policy's impact—particularly on patients in underserved communities—and establish clear guidelines to ensure premium dollars are effectively used to improve care quality, safety, and equity.

Conclusion

The NHC appreciates the opportunity to provide input on the 2026 NBPP proposed rule. Please do not hesitate to contact Jennifer Dexter, Vice President of Policy and Government Affairs, at jdexter@nhcouncil.org if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer