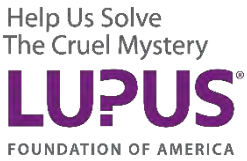



November 12, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
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)

Dear Secretary Becerra and Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the Notice of Benefit and Payment Parameters for 2026 Proposed Rule, issued by the Department of Health and Human Services (HHS).

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

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

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

Navigators and Consumer Assisters: Standards for Referring Consumers to Programs Designed to Reduce Medical Debt

Medical debt affects a staggering number of people in the United States. In 2022, more than 100 million people had debt as a result of health care bills, while more than half the adult population had incurred medical debt at some point within the previous five years.[2] As these numbers suggest, medical debt affects individuals from a range of backgrounds and demographic characteristics; however, its burdens are borne disproportionately by people of color and individuals with lower incomes.[3]

The consequences of medical debt can be long-lasting and significant. Medical debt can be financially destabilizing, leading to reductions in spending on food, clothing, and basic household items; the erosion of household savings; skipped student loan and mortgage payments; and changes in a person's housing situation (e.g., needing to move in with family or friends).[4] Adults with medical debt also may have a harder time accessing needed care and are more than twice as likely to say they or a member of their household have delayed care due to its cost.[5]

We thank the administration for its commitment to addressing the causes and burdens of medical debt. Further, we share the Department's view that there is a role for Navigators and other ACA enrollment

[1] Partnership to Protect Coverage, *Consensus Healthcare Reform Principles*, https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles. Mar. 2017.

[2] Lopes L. et al., "Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills," *KFF*, https://www.kff.org/health-costs/report/kff-health-care-debt-survey/. June 16, 2022. Even after the country's three largest credit reporting agencies agreed to remove many medical bills from consumers' credit reports (because they are not generally predictive of creditworthiness), the Consumer Financial Protection Bureau has estimated that at least 15 million Americans still have medical debt reflected on those reports. CFPB, *CFPB Finds 15 Million Americans Have Medical Bills on Their Credit Reports*, https://www.consumerfinance.gov/about-us/newsroom/cfpb-finds-15-million-americans-have-medical-bills-on-their-credit-reports/. Apr. 29, 2024.

[3] Lopes et al., "Health Care Debt in the U.S." 2022.

[4] Id.

[5] Id.

assisters (collectively, "enrollment assisters") to play in connecting consumers at risk of incurring medical debt with resources that may help them avoid it. We believe the Department's interest in developing standards for enrollment assisters located within hospitals, or that are part of hospital systems, to encourage or require them to help in this way, makes sense. Hospital bills are a key driver of medical debt; federal law requires nonprofit hospitals to have a written financial assistance policy, and a growing number of states have established rules designed to make hospital financial assistance programs more accessible and effective.[6] In short, hospital-based enrollment assisters are well-placed to help consumers access resources that in many cases are — or should be — housed within the same institution.

That said, to reduce the risk of consumer harm, we urge the Department to provide guardrails governing the circumstances in which enrollment assisters may refer consumers to medical debt resources and financial assistance programs. For example, it must be clear — in regulation and to consumers — that any services that enrollment assisters offer in relation to medical debt must be provided to the consumer free of charge and that enrollment assisters may not accept compensation for any referrals they make. The Department should also develop guidance for enrollment assisters to ensure they are connecting consumers to reputable resources. Because, as noted above, many hospitals have existing obligations to provide financial assistance to patients and/or are otherwise subject to community benefit requirements, enrollment assisters should be educated on these programs and be able to direct patients to them. We also suggest that HHS require enrollment assisters to document their referrals and ask the Department to consider what other data reporting may be necessary in order to understand how this initiative is working for consumers and may be affecting stakeholders.

Finally, we are deeply appreciative of the administration's funding support for the Navigator program. If the Department does determine to expand the services that these enrollment assisters should or must provide, it will be essential to maintain this level of robust investment.

Oversight and Enforcement of Standards Governing Agents, Brokers, and Web-Brokers

Most agents and brokers work constructively to help consumers understand their health insurance options and have enrolled many people in comprehensive coverage. At the same time, agents and brokers have financial conflicts of interest — conflicts that Navigators and the marketplaces themselves do not have — that are not always well managed and that have led to consumer harm.

Throughout 2024, the Department has received tens of thousands of complaints from consumers who were enrolled in marketplace coverage, or switched from one marketplace plan to another, by an agent or broker acting without the consumer's consent.[7] These practices put consumers in a terrible position. Consumers who are enrolled without their knowledge or consent in coverage that may not be suited to their needs are more likely to experience delays or disruptions in accessing care and face unexpected costs from issuers and providers. If an agent or broker submits an unauthorized application that includes inaccurate income or household information, the consumer's eligibility for premium tax credits (PTCs) will be miscalculated and they may be exposed to tax liability as a result.

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[6] See Kona M., "State Options for Making Hospital Financial Assistance Programs More Accessible," *Commonwealth Fund*, https://www.commonwealthfund.org/blog/2024/state-options-making-hospital-financial-assistance-programs-more-accessible. Jan.11, 2024.

[7] See CMS Statement on System Changes to Stop Unauthorized Agent and Broker Marketplace Activity, CMS Statement on System Changes to Stop Unauthorized Agent and Broker Marketplace Activity | CMS. July 19, 2024.

We appreciate the Department's ongoing work to address these abuses and to ameliorate the harms experienced by affected consumers. This is a problem we believe warrants a legislative response and we support congressional efforts to establish additional statutory safeguards governing agent/broker-facilitated enrollment and impose tougher civil and criminal penalties for misconduct.[8] Whether or not Congress acts, however, it is critical for the Department to continue to improve oversight and enforcement in this area. We thank the Department for its proposals to do so; we fully support these efforts and offer the following additional suggestions.

Oversight at the Agent/Broker Organization Level
While we presume that many of the recent unauthorized enrollments and plan switches affecting marketplace consumers were the work of rogue actors working alone, it appears some abuses were endorsed or even orchestrated by the company or agency with which the perpetrator(s) were affiliated. For example, the proposed rule notes that the Department has seen agency materials instructing agents and brokers to fabricate enrollee or applicant incomes on marketplace eligibility applications. The Department also relates that it has reviewed agency procedures and directives that instruct agents and brokers to avoid speaking with the consumer until *after* the person has been enrolled.

These revelations — of organization-level policies and practices designed to mislead consumers (and, it would appear, defraud the government) — are deeply troubling. They demonstrate that it is essential for the Department to engage promptly in more robust oversight of "lead agents" and to take enforcement action where appropriate. We agree that existing authority permits this approach and strongly encourage the Department to proceed with its plans to use this authority to hold agent/broker agencies accountable for misconduct and noncompliance at the agency level.

Authority to Immediately Suspend Agents and Brokers from Transacting with Marketplace IT Systems
Similarly, while we are of the view that the statute and the existing regulatory text describing the Department's authority to immediately suspend an agent or broker from transacting information with marketplace information technology systems are sufficiently broad to allow the Department to act when it discovers circumstances that pose an unacceptable risk to applicants or enrollees, we support, in the interest of transparency, the proposal to clarify this authority. There should be no doubt that the Department can and will act promptly to stop misconduct or non-compliant behavior that jeopardizes consumers.

In addition, we ask the Department to consider additional actions it might take to ensure all interested parties, including the public, are sufficiently aware of bad actors operating in this market. For example, we believe the Department should share, to the fullest extent it is able, the identity of agents, brokers, and web-brokers with system suspensions (and/or whose Exchange Agreements have been suspended or terminated) with state regulators, marketplace issuers, and the public.

Finally, we urge the Department to clarify that an agent, broker, or web-broker that is under a system suspension imposed by HHS may not, during that time, transact information with any state-based marketplace system. It is highly likely that an entity that poses an unacceptable risk to the federal marketplace and its consumers presents the same danger to any state marketplace with which it does business, and to their consumers. Marketplace consumers put at unacceptable risk should receive the benefit of a prompt regulatory response, regardless of where they live.

[8] See the Insurance Fraud Accountability Act, S. 4767, https://www.congress.gov/bill/118th-congress/senate-bill/4767/text.

Premium Payment Thresholds

Current rules give issuers the option to effectuate a consumer's coverage, or allow an enrollee to remain in coverage, if their premium payment meets or exceeds a predetermined threshold. For example, an issuer that adopts a premium payment threshold of 95 percent will effectuate coverage for a consumer who pays 95 percent or more of the premium owed (e.g., they pay $95 on a $100 premium bill). These rules specify that an issuer's payment threshold (if any) *must* be percentage-based and *can* be set at 95 percent, though other "reasonable" thresholds are also permitted.

We support this policy, which promotes continuity of comprehensive coverage. Consumers who intend to obtain and maintain health insurance may, due to other financial pressures or simple error, fall behind on owed premium by a de minimis amount. Issuers should not be required to deny or terminate coverage in these cases.

Indeed, we believe consumers (and issuers) would benefit from greater flexibility in this area. The requirement that a payment threshold be percentage-based is unnecessarily restrictive and can lead to perverse outcomes. If, for example, a consumer selects a plan with a $100 gross premium and is determined eligible for a PTC of $98, their premium obligation is $2. If the consumer pays $1, the issuer will receive 99 percent of the premium. Yet in this scenario, the issuer is nevertheless required to terminate coverage because the consumer has not met the 95 percent payment threshold. This is a problem, and a large one: the Department calculates that more than 80,000 marketplace policies were terminated in 2023 alone because the enrollee owed $5 or less.[9]

To address this problem, HHS proposes to allow issuers to adopt other types of payment thresholds: specifically, either a fixed-dollar premium threshold of $5 or less, or a percentage threshold based on the gross (pre-tax credit) premium. Notably, however, the Department would not permit issuers to apply these thresholds to a consumer's initial (binder) payment to effectuate coverage. The proposed rule would also limit issuers to using just one type of threshold.

We thank the Department for its attention to this issue and support the proposal with modifications. While the Department's approach is generally consistent with the policy goals animating the existing rules, we believe it would be more consistent and more effective to let issuers apply the new thresholds to binder payments if they choose to do so. Most enrollees through HealthCare.gov qualify for a plan with a premium of $5 or less.[10] We do not believe issuers should be required to treat one such consumer, who may be a dollar short on their January binder payment, differently from another who is a dollar short on the same nominal payment in February. We appreciate that the Department is cautious about allowing coverage effectuations in circumstances where a consumer has made no payment. We note, however, that in 2024, more than 40 percent of HealthCare.gov enrollees chose a plan with $0 premium and enrolled in that coverage without making a payment.[11] We believe issuers should have the option to effectuate coverage for otherwise similarly situated individuals who have not yet made payment on a nominal premium.

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[9] An additional 100,000 individuals had their 2023 coverage terminated as a result of a premium debt of between $5.01 and $10.

[10] See CMS, *Health Insurance Marketplace 2024 Open Enrollment Report*, https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.

[11] Id.

In addition, we urge HHS to allow issuers to employ more than one payment threshold if they wish to do so. The proposed rule suggests that allowing this degree of flexibility may introduce too much complexity. It appears to us unlikely, however, that using more than one threshold will create additional confusion on the part of consumers (relative to a situation where just one threshold is employed), while there are likely to be real benefits for at least some consumers if issuers are able to employ multiple of these mechanisms to facilitate coverage continuity. To the extent a given issuer determines it is too complex from an operations standpoint to implement multiple thresholds, it need not do so.

Requirements for Filing an Appeal of an Eligibility Determination

Current rules allow individuals meeting the definition of "application filer" to apply for coverage on HealthCare.gov on behalf of another person (the applicant). Application filers include an adult in the applicant's household or family, the applicant's authorized representative, or, if the applicant is a minor or incapacitated, someone acting responsibility on their behalf.

The proposed rule would allow application filers to file an appeal of a contested eligibility determination on behalf of the applicant. We support this proposal for the reasons set forth by the Department, with the understanding that the definition of application filer includes only those individuals who may fairly be considered to be acting with the authorization and/or consent of the applicant.

Certification Standards for Qualified Health Plans

The ACA states that a marketplace "may" certify a health plan as a qualified health plan (QHP) if the plan meets applicable certification requirements "and" the marketplace determines that making the plan available for sale through the marketplace is in the interests of consumers. This statutory language grants marketplaces broad discretion over the decision of whether to certify a plan, straightforwardly permitting a marketplace to deny certification to any plan that does not satisfy minimum standards.

The Department proposes to amend existing regulations to recognize explicitly the authority of marketplaces to deny certification of a health plan that does not meet applicable standards. The proposal is consistent with the ACA — indeed, we believe the statutory text compels this reading — and we support its adoption.

Public Release of State Marketplace Reports and Related Materials

Under existing rules, the state-based marketplaces (SBMs) must provide to HHS certain reports, results from independent audits, and other data that describe marketplace activities and performance. These materials are used by HHS to monitor and evaluate the SBMs' compliance with their regulatory and statutory obligations.

The Department proposes to begin releasing some of these materials to the public and to publish additional information that it already collects regarding SBM operations and functionality (for example, SBM spending on outreach and call center and website metrics).

We support this proposal. We agree that marketplace operations and performance should be more transparent and believe that public release of materials that shed light on these areas can help improve understanding of the marketplaces and facilitate policy research and development.

Reducing the Risks Posed by Issuer Insolvencies

HHS observes that, when an issuer becomes insolvent, it can be both destabilizing for the market(s) in which the entity operated and hugely disruptive to its enrollees. The Department solicits comment on how it might work together with state regulators to reduce the risks posed by issuer insolvencies.

We agree with the Department's assessment of these risks and thank you for your attention to them. Insurer insolvencies can be especially problematic for the patients we represent because they may disrupt active treatments and complicate access to their chosen providers. An insolvency that forces a consumer to switch coverage mid-year, in addition to being particularly stressful for someone facing a serious medical condition, may expose the individual to significant additional costs if, for example, their spending against the deductible and out-of-pocket limit under the insolvent plan is not credited by their new coverage.

We strongly support the Department's proposal to coordinate more closely with state regulators and the National Association of Insurance Commissioners to reduce the risks of insolvencies. As you do so, we ask that you and your state partners exercise the full extent of your regulatory authority to ensure that enrollees are held harmless from the negative effects of an insolvency if/when one occurs.

User Fee Rates for the 2026 Benefit Year

HHS proposes that the 2026 user fee rates for issuers that participate on the federally facilitated marketplace (FFM) or through an SBM using the federal platform will be 2.5 percent and 2.0 percent, respectively. We understand the Department's view that the proposed user fee rates, which would be modestly higher than in recent years, are necessary in the event the current enhancements to the federal PTC are allowed to expire at the end of 2025.

We believe it is absolutely critical for Congress to extend the expanded PTCs, which are responsible for large gains in coverage affordability and enrollment.[12] Yet whether or not Congress eventually acts, we believe the Department is warranted in finalizing user fee rates that are higher than those of recent years. This administration has done much to help connect consumers with the marketplace and to improve their ability to navigate the portal and access the coverage they need. This work has been hugely beneficial to consumers (and the health plans that enroll them) and we are grateful for it. We believe the proposed user fee rates properly reflect the benefits plans are receiving from the marketplace and are at a level that should enable HHS to maintain its investments in the program. We therefore suggest they should be finalized as proposed.

Silver Loading

The ACA requires issuers to provide cost-sharing reductions (CSRs) to qualifying marketplace enrollees (generally, those with household incomes at or below 250 percent of the federal poverty level who select a silver marketplace plan). By statute, the cost to insurers of providing CSRs is to be reimbursed by the federal government. In October 2017, the Trump administration determined to stop providing CSR reimbursements until such time as funds to cover these costs were specifically appropriated by Congress.

In response to the discontinuation of federal funding for CSRs, the vast majority of state insurance departments permitted or directed their issuers to increase premiums for on-marketplace silver plans, a

[12] See, e.g., Ortaliza J. et al., "Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?" *KFF*, https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/. July 26, 2024.

practice generally known as "silver loading." As the Department knows, the specific manner in which silver loading has been implemented has varied. For years now, states, acting in their role as the primary regulator of insurance rates, have pursued various approaches to the practice, subject to their own state laws and applicable federal regulations.

Throughout this time, the federal position on silver loading has been clear. From the outset, during the prior administration and in this one, the Department has consistently affirmed that silver loading is permitted under the statute and existing regulations. This has been the understanding of essentially all stakeholders — HHS notes that all commenters on a 2019 proposed rule discussing this issue recognized that silver loading is appropriate — and it is our understanding, as well.

In the proposed rule, the Department again affirms the permissibility of silver loading and says it is considering whether to codify the practice explicitly. We have no objection to the Department providing additional clarity, in regulation, that silver loading is allowed.

Conversely, we do not believe it is necessary or appropriate to do more than simply codify the practice in which the states have long been engaged. While we do not read the proposed rule to suggest that the Department is considering doing more, such as imposing new restrictions on how states have long implemented silver loading, we note that we would oppose any such changes.

Standardized Plan Options

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

Current regulations set modest limits on the number of non-standard plans that issuers can offer while also providing for an exceptions process that allows issuers to exceed these limits. As we have previously explained, we strongly support a cap on non-standard plans and oppose allowing exceptions to that limit.[13] Consumers confronted with too many health plan choices are more likely to make poor enrollment decisions or experience choice paralysis and forgo enrollment altogether. Research suggests "too many" in this context means having more than 30 options; in 2024, the weighted average number of plans available to a Marketplace consumer is 91.8.[14]

[13] Partnership to Protect Coverage, Patient Priorities for the 2026 Notice of Benefit and Payment Parameters, https://www.protectcoverage.org/siteFiles/46539/06072024%20PPC%202026%20Policy%20Priorities%20for%20NBPP.pdf. June 7, 2024.

[14] See Chu R.C. et al., "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces," *ASPE*, https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf. Dec. 28, 2021.

Not only do marketplace consumers often face an unmanageably large number of plan choices, they frequently may find that many of their options are actually quite similar and difficult to differentiate between. To the extent there is any value to consumers in being able to select between nearly identical variations of an already complicated product — and we are not sure there is — it is far outweighed by the practical burdens of having to wade through duplicative offerings and the high likelihood of confusion while doing so. Accordingly, we have previously urged the Department to reestablish standards requiring that an issuer's marketplace plans be meaningfully different from each other.

We thank the Department for recognizing, in the proposed rule, that allowing issuers to offer identical (or near identical) standardized plan options undermines the goals of enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process, and that this practice poses a risk of significant consumer confusion. We agree with this reasoning and generally support the proposal to require marketplace issuers to offer standardized plans that are meaningfully different with respect to benefits, provider networks, and/or formularies. We appreciate that the Department is committed to monitoring how issuers are complying with this standard, including determining the extent to which plans may be adhering to the letter but not the spirit of the policy. Oversight of issuer behavior, over time, will be important. Still, we urge the Department to clarify, sooner rather than later, what sort of variations in benefit design, in particular, would be "material" (such that they would satisfy this standard), as this element appears susceptible to gaming.

Finally, we note that the Department's well-reasoned justifications for establishing a meaningful difference standard for standardized plans apply with equal force to issuers' non-standard marketplace offerings. Just as it is hard to discern any benefit to consumers of two plans that, in addition to having standardized cost-sharing, have been crafted to be identical in all other respects, so too is it difficult to see consumer value in two ostensibly non-standard options that are in fact duplicative across their feature set. As the Department watches to see how issuers are responding to the meaningful difference standard for standardized plans, we ask that you monitor for duplicative non-standard options and consider requiring meaningful differences among these plans, too.

Network Adequacy: Essential Community Provider Reviews

The ACA requires marketplace plans to include within their networks essential community providers (ECPs) that serve predominately low-income, medically-underserved individuals. As part of the annual QHP certification process for issuers seeking to offer coverage through the FFM, the Department reviews prospective QHPs for compliance with ECP standards. Since 2015, federal review of ECP standards has occurred in some, but not all FFM states: in FFM states that perform plan management functions, systems limitations have caused the Department to rely on the states to conduct ECP reviews.

Following system updates, HHS can now review ECP data for issuers in all FFM states, including those performing plan management functions. The Department therefore proposes to conduct independent ECP certification reviews for all plans seeking QHP certification on the FFM. We support this proposal. We agree that Department review of ECP data in all FFM states will provide greater consistency in oversight and enforcement of ECP requirements and thereby facilitate timely access to care for low-income and medically-underserved consumers.

Publication of Quality Improvement Strategies

Under the ACA, QHP issuers must develop and implement a Quality Improvement Strategy (QIS) to enhance health care quality and performance. Each QHP must submit two quality improvement strategies that include increased reimbursement or other incentives to improve health outcomes, with

at least one strategy focused on reducing disparities among historically marginalized populations. While insurers have submitted their QIS to HHS, details about these programs, including the specific clinical areas they aim to address, have not been publicly disclosed.

We strongly support the Department's proposal to share a summary of QIS data publicly. Since these programs are designed to improve patient care, we believe the topic area, information on incentives, the targeted populations, and Quality Rating System measures should be shared with patients and the public. We believe this proposal will arm patients and interested parties with information needed to inquire further about the implementation of these quality-improving programs. We also believe publication of this information will bring essential transparency to the quality of health insurance plans and foster innovation among issuers to improve health care access. We appreciate the Department for taking this important step.

Risk Adjustment: Proposed Inclusion of Pre-Exposure Prophylaxis (PrEP) as an Affiliated Cost Factor
As HHS recognizes, current risk adjustment methods fail to offset the additional costs borne by issuers who attract many enrollees who receive PrEP. This is because PrEP receipt is not triggered by any active diagnosis and thus not reliably associated with the factors already included in the Department's models. We share the Department's concern that this current approach thus may inadvertently incentivize issuers to restrict access to PrEP, such as by imposing cumbersome prior authorization requirements, in an effort to avoid enrollees who need the medication.

In response to this issue, HHS proposes to include the receipt of PrEP as an affiliated cost factor in its risk score models. We support this proposal, which we agree should mitigate incentives to avoid enrollees who use PrEP and thereby help ensure appropriate access to this high-value preventive service. We also agree with the Department that overprescribing of PrEP in response to this change is unlikely due to the hassle and other costs recipients of the medication must bear.

Risk Adjustment: Time Value of Money
Under current practice, risk adjustment transfers happen 8-10 months after the end of each benefit year. However, the differences in claims costs that risk adjustment is designed to offset largely accrue during the benefit year or shortly thereafter.

Because of the time value of money, these payment lags prevent the risk adjustment system from fully compensating issuers with above-average actuarial risk for the additional costs they bear because they serve higher-risk enrollees, and it allows issuers with below-average risk to retain some of the benefit they receive by attracting lower-risk enrollees. Concretely, issuers with below-average risk can invest their claims savings between when claims payments are made and when transfers occur, while issuers with above-average risk lose the chance to invest these funds. The failure of the risk adjustment program to account for the time value of money thus makes it less effective at mitigating issuers' incentives to avoid higher-risk enrollees.

We are concerned that issuers offering coverage in the individual market perceive strong incentives to avoid higher-risk enrollees — and that this is causing issuers to shy away from offering plans that offer more robust coverage, thereby narrowing the choices available to consumers. For example, platinum plans, preferred provider organization plans, and plans with broad networks are either rare or

completely unavailable in many areas.[15] While the failure of the current risk adjustment program to account for the time value of money is likely not the only factor driving this outcome, we believe it is a contributing factor.

We thank the Department for soliciting input on how the time value of money affects the risk adjustment program's effectiveness and support efforts to begin taking account of the time value of money in calculating risk adjustment transfers.

Timing and Length of Public Comment Period

As the Department knows better than anyone, the annual notice of benefit and payment parameters rulemaking, including the notice and comment process, is a significant undertaking. We thank the Department for its work to release this proposed rule earlier than has been typical in past years but respectfully request that, in future years, you maintain a public comment period of at least 45 days.

Additional Recommendations Relating to Network Adequacy, Essential Health Benefits, and Patient Cost-Sharing

We reiterate our gratitude to the administration for its stewardship of the ACA marketplaces and its work to improve coverage for all patients. As these efforts continue, we urge you to consider additional policies to strengthen consumer protections related to provider network adequacy, EHB, and patient cost-sharing, along the lines of recommendations we have offered previously.[16]

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Thank you for the opportunity to provide these comments. If you have any questions, please contact Bethany Lilly at The Leukemia & Lymphoma Society (bethany.lilly@lls.org).

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
CancerCare
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Lupus Foundation of America

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[15] See, e.g., Graves J.A. et al., "Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets, *JAMA*, https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2774285. Dec. 17, 2020. CMS, *Plan Year 2024 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces*, https://www.cms.gov/files/document/2024-qhp-premiums-choice-report.pdf. Oct. 25, 2023.

[16] See Partnership to Protect Coverage, *Patient Priorities for the Notice of Benefit and Payment Parameters*, https://www.protectcoverage.org/siteFiles/46539/06072024%20PPC%202026%20Policy%20Priorities%20for%20NBPP.pdf and https://www.protectcoverage.org/siteFiles/45068/07%2027%202023%20PPC-2025-Policy-Priorities-for-NBPP.pdf.

March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Eczema Association
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society