FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

November 12, 2024

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9888-P
PO Box 8016
Baltimore, MD 21244-8016.

Submitted electronically via regulations.gov

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program Proposed Rule (CMS-9888-P)

Dear Administrator Brooks-LaSure:

As a leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to comment on the Notice of Benefit and Payment Parameters for 2026. For more than 40 years, Families USA has been dedicated to achieving high quality, affordable health care and improved health for all. We seek to make concrete and tangible improvements to the health and health care of the nation — improvements that make a real difference in people's lives. The health insurance marketplaces and plans established under the Affordable Care Act have tangibly improved our nation's health by, among other things, providing comprehensive coverage to 21 million people in 2024 who do not have affordable job-based coverage.[i]

The 2026 Notice of Benefit and Payment Parameters would make modest changes to plan parameters and improve U.S. Department of Health and Human Services (HHS) oversight of agent and plan activity. We support those proposals, offer comments and recommendations to strengthen them, and strongly encourage the Centers for Medicare and Medicaid Services (CMS) to codify this rule into the federal code prior to the end of the current administration. Below are comments and recommendations focused on the following:

- Assistance to Reduce Medical Debt: 45 CFR Part 155.210, 155.215, and 155.225;
- Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220): Improvements in oversight of agents, brokers, and web-brokers;
- General Program Integrity and Oversight Requirements (§ 155.1200): Exchange metrics to disclose to the public;
- Silver Loading (§ 156.80): Codification of previous guidance allowing certain silver-loading practices;
- AV Calculation for Determining Level of Coverage (§ 156.135): Publication of the actuarial value calculator; and
- Recommendations for Network Adequacy

Assistance to Reduce Medical Debt: 45 CFR Part 155.210, 155.215, and 155.225

CMS asks for comment on how assisters who perform their duties in a hospital and hospital system may, within the bounds of the statute, refer consumers to programs designed to reduce medical debt. Families USA offers several recommendations and comments related to assistance with medical debt.

Background on Medical Debt

Medical debt affects more than 100 million Americans, including those enrolled in marketplace plans. A 2023 Commonwealth Fund survey found that 33 percent of people with marketplace or individual market plans were paying off medical debt.[ii] Another recent survey showed that people with medical debt are financially vulnerable because they have often experienced a large drop in income and may use payday loans or other costly and risky arrangements to pay off their debt. They are also more likely to put their health at risk by delaying or foregoing medical care due to cost.[iii] While it is essential to enact policy solutions that directly protect consumers from being exposed to medical debt, it is as important to address the fact that high and rising health care prices, particularly hospital and drug prices, are a major driver of people not being able to afford their medical bills. Policy solutions to get at these root causes include strengthening hospital and health plan price transparency rules; enacting site-neutral payments across key services to ensure consumers pay the same price for the same service, regardless of where they receive care; and addressing anticompetitive contracting practices that restrict consumer access to lower-cost, higher-value care by strengthening enforcement and oversight over health plan and provider contract negotiations. Only by addressing medical debt from multiple perspectives, including both advancing consumer protections *and* tackling the root causes of high and rising health care prices and costs, can we meaningfully alleviate the economic insecurity that families experience due to health care debt.

Avenues for Navigators and other assisters to aid consumers in reducing medical debt include:

- Appealing coverage denials;
- Accessing hospital financial assistance programs, including those that tax-exempt hospitals are required to provide under the Internal Revenue Code;
- Applying for "medically needy" Medicaid coverage, if eligible;
- Obtaining assistance with retroactive claims, including out-of-network PPO claims and claims for out-of-network coverage under the No Surprises Act;
- Securing relief from programs administered by non-profits such as disease societies and United Way agencies.

Recommendations

Families USA recommends adding to the proposed rule that a Health Insurance Exchange may require or authorize Navigators and other assisters to provide information and assistance on available resources to reduce medical debt. The statute explicitly references many of these resources. For example, under 1311(i), Navigators must refer enrollees to appropriate agencies to assist them with grievances, complaints, or questions regarding a coverage denial. Public use data shows that in 2021, healthcare.gov insurers denied 17% of in-network claims,[iv] so appealing those denials could help some

consumers avoid debt. Other sources of help explicitly referenced in the statute are patient navigator programs, which help people find affordable treatment. This is mentioned at section 3510 of PPACA (and 42 USC 256(a)).

Assisters and Navigators should also educate enrollees about using in-network providers when possible, understanding their protections under the No Surprises Act, choosing plans with cost-sharing structures that work best for them, and getting information about their costs for scheduled care.

People often need assistance in finding the exchange plan that best meets their health and financial needs given their likely expenses. As discussed in the recent report of the Marketplace Affordability Project, deductibles and cost-sharing burdens in marketplace plans can leave people with medical debt and unable to afford needed medical care.[v] For example, if a patient with a scheduled surgery chose standard plan option one (FR p. 82381), they would have to meet a $6000 deductible and then pay 40% of hospital care. In that instance, a Navigator or assister could help the patient obtain a determination of their eligibility for hospital financial assistance to help cover the cost of that care, or determine if they would face fewer expenses under a different plan.

Navigators and assisters can also provide information about coverage options, including Medicaid, CHIP, and state-funded programs, for other members of the enrollee's family who may not quality for marketplace coverage.

Consequently, CMS and state-based exchanges should train Navigators and assisters on how to help people avoid medical debt. That training should include how consumers can appeal insurance denials and use financial assistance programs in nonprofit hospitals, information about state laws regarding financial assistance, and coverage options for family members not eligible for marketplace assistance.

CMS should consider utilizing multiple funding streams to ensure that assisters are adequately funded to provide this assistance. We believe it is entirely appropriate for Navigators and assisters to inform people about available resources to address medical debt and to help them with applications as needed. Additional funding would ensure that helping people with hospital financial assistance or other forms of assistance will not detract from the assisters' central duties during open enrollment season.

In sum, we recommend adding to the rules:

- **At 155.210 (e)(9), that an Exchange may require or authorize Navigators to provide information and assistance on available resources to reduce medical debt.**
- **At 155.225(c), that certified application counselors may be trained and certified to assist individuals and employees with locating publicly available resources as well as hospital financial assistance programs established under IRC Section 501(r)4) and under applicable state laws to reduce medical debt. Additional funding and training to ensure that Navigators and assisters are equipped to take on these duties.**

Ability of States To Permit Agents and Brokers and Web-Brokers To Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220): Improvements in oversight of agents, brokers, and web-brokers;

Families USA supports the actions proposed in this rule to strengthen oversight of lead agents, brokers, and web brokers. The proposed rule would better reflect CMS's statutory authority to suspend agents or brokers from Exchange transactions when there is unacceptable risk of inaccuracy or noncompliance with standards of conduct, and to impose civil money penalties for noncompliance.

CMS is already using these authorities to aggressively investigate complaints about agent and broker actions and weed out bad actors. As noted in an October 2024 press release, from January 2024 through August 2024, CMS received 90,863 complaints about unauthorized plan switches, and 183,553 complaints that consumers were enrolled in federal marketplace coverage without their consent.[vi] CMS reports that it has resolved the vast majority of these cases and suspended 850 agents' and brokers' marketplace agreements, successfully addressing a trend that appears to have begun in the last several years. GAO investigators in 2021 found that brokers listed on healthcare.gov whom they investigated did not engage in deceptive marketing and referred people to appropriate, ACA-compliant plans.[vii] It is important for CMS to be able to stay on top of new deceptive agent and broker scams as they arise.

We support CMS proposals to strengthen its oversight of brokers, but we hope that the agency's budget will also support and delineate these activities. Oversight could include system monitoring and review of agency training manuals and marketing materials.

Finally, we request that CMS clarify that when it discovers fraudulent and unwanted enrollments, both the enrollments and the associated premium tax credits paid to that plan will be cancelled retroactively to the enrollment date. In April 2024, a news report noted that when fraudulent enrollments are cancelled, enrollees might still be on the hook for premium tax credits that were paid to the insurer.[viii] Families USA recommends that the Marketplace send notices to affected enrollees documenting the retroactive termination so that enrollees have proof in the event of any disputes about their tax liability**. We request that CMS and IRS work together to hold consumers harmless and notify tax filers about what to do if they learn upon filing their taxes that they received unneeded tax credits through a fraudulent enrollment through no fault of their own.**

Deceptive Marketing

We recommend that federal agencies continue to address deceptive and confusing marketing by organizations whose websites sell non-ACA plans. Some organizations have websites that might appear to consumers to be official, government-sponsored sites, but they are in fact selling non-ACA-compliant plans and/or offering only a fraction of available qualified health plans (QHPs). A Families USA search on Bing for "marketplace health insurance" on October 21, 2024, turned up the following five non-government websites before listing healthcare.gov: dc-healthcare.org; affordablehealthplans.org; pickhealthinsurance.com; obamacare-rates.com; and health-plan-enrollment.com. Only two of the five websites had disclaimers at the bottom that they were privately operated and not affiliated with the US government.

General Program Integrity and Oversight Requirements (§ 155.1200): Exchange Metrics to Disclose to the Public

CMS proposes collecting and making publicly available more information about metrics. We would like further information in transparency in coverage public use files in all states.

We believe marketplace plans in all states should report "transparency in coverage" data[1] to the federal government and to their state departments of insurance, and that the measures should be refined to collect more specific data. It would be particularly helpful to get data from plans offered in state exchanges and the federal exchange on specific reasons for in-network claim denials. A 2023 report by KFF showed high rates of in-network claim denials in plans offered on HealthCare.gov (17%) and the highest proportion of those denials (77%) were classified as for "all other reasons." A smaller percentage, 14%, were denied because the claim was for an excluded service. A stakeholder discussion could help elucidate typical "other reasons" and what further data classifications might be helpful. For example, do patients get a substitute service or drug that the plan does cover? How can we better discern problematic denials of care and ensure that they are appealed and resolved?

We are also interested in data about the number and type of claims, and the typical cost of claims, that patients are absorbing because they have not met their deductible. To the extent that it is available, data on these pre-deductible claims by income or cost-sharing reduction (CSR) level and race and ethnicity could help insurers and policymakers design plans that are equitable and responsive to enrollee needs. For example, a literature review in 2021, "Impacts of high-deductible health plans on patients with diabetes; A systemic review of the literature" indicated that patients with diabetes with high-deductible health plans were less likely to adhere to treatment and prescription refills than their counterparts in low-deductible plans.[ix] Beginning in 2025, under 45 CFR §156.202, issuers may be offering non-standardized plan options that lower cost sharing on selected services in order to benefit people with chronic conditions. Data about health care utilization in these plan variants could inform future plan designs.

Silver Loading (§ 156.80): Codification of previous guidance allowing certain silver-loading practices

CMS has requested public comment on whether to codify previous guidance indicating that certain silver-loading practices are allowed.

We support codifying through rulemaking that certain silver-loading practices are permissible, and we agree that silver-loading is a justifiable way to vary premium rates given the loss of federal funding for cost-sharing reductions. As noted in the preamble, both administrations that have addressed silver loading have concluded that this practice is permitted under the statute and under current regulations. It is also consistent with court decisions. Section 1402 of the ACA (42 USC 18071) clearly requires issuers to reduce cost sharing for eligible enrollees by reducing the out-of-pocket limit and raising the actuarial

[1] That is, data on issuer and plan-level claims, appeals, and active URL data similar to current Public Use Files.

value of plans. In turn, the statute requires the Secretary to pay the issuer an amount reflecting the increased actuarial value.

Though federal direct payment of cost-sharing reductions (CSRs) ended in 2017, in 2020 the Federal Circuit Court of Appeals concurred that insurers were entitled to reimbursement for CSR payments.[x] Insurers and regulators have compensated insurers for required CSRs by allowing them to add these costs to premiums, most commonly as a "silver load," which applies the additional costs exclusively to silver plan premiums.[xi]

In addition, Families USA supports silver loading because it gives enrollees access to reasonably priced silver plans and often gives them enough assistance to purchase higher value plans.[xii] Some states have thoughtfully considered silver-loading approaches that comply with the statute and are in the best interest of enrollees. They have given plans uniform factors to use in silver-loading that comply with federal law.[xiii] Texas, for example, requires a CSR adjustment factor of 1.35 for silver plans on the exchange.[xiv] New Mexico prescribes induced demand factors and a CSR adjustment.[xv] Vermont and Illinois recently joined the list of states that prescribe specific silver-loading factors. We agree the rule should respect regulators' traditional jurisdiction over rate setting, within the bounds laid out in federal law.

Regulators and advocates can learn from states' approaches and CMS should facilitate that information sharing. For example, Vermont's Green Mountain Board found that when carriers calculated their own silver load, it could not be audited during rate review and differences in calculation methodologies potentially contributed to anti-competitive outcomes, where one carrier unfairly charged lower premiums on the most profitable exchange silver plans. Revised guidance in Vermont now requires carriers to utilize a common silver load calculated by the Board using carrier-supplied enrollment data. The revised guidance also incorporates induced demand in silver loads that reflect the level that CMS's risk adjustment assumes. Finally, Vermont's revised guidance assumes enrollment shifts out of low actuarial value (AV) silver plans, which increase the average silver benefit level and thus also increase the silver load.[xvi] Illinois recently engaged in a study of premium misalignment pursuant to findings of its General Assembly that premiums in its marketplace were not reflecting coverage generosity of the plans.[xvii] The resulting study found that realignment of on-exchange premiums would probably increase enrollment for households with incomes from 201-400% of the federal poverty level and increase the overall proportion of residents with insurance. Illinois has elected to prescribe factors to be used by all carriers for CSR loading, and to apply CMS's induced demand slope to actuarial values.[xviii] In doing so, Illinois considered both its goals of creating consistency and promoting affordability, and the need to prevent market disruption as it moved to a new system.[xix]

We recommend using the following language in a regulation that codifies silver loading:

> **Permitted plan-level adjustments to the index rate**. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(i) The actuarial value and cost-sharing design of the plan, **including cost-sharing reductions under Subpart E of this Part 156 if not paid for under section 156.430.**

AV Calculation for Determining Level of Coverage (§ 156.135): Publication of the actuarial value calculator;

CMS intends to change the process for public comment on a proposed AV Calculator. Instead of releasing a proposed calculator for public comment through guidance and then finalizing it in the last quarter of the year before it is to go into effect, CMS intends to release only a single, final version of the calculator by or before the beginning of the preceding plan year. The public would be able to comment on the calculator methodology for the following plan year.

We are concerned about this approach because it does not give state-based exchanges enough time to evaluate proposed plan designs against the calculator and finalize plan designs in time for open enrollment. Families USA participates in the DC Health Benefit Exchange's Standard Plan Workgroup that updates the standard plan design in the District of Columbia to address health disparities. In the fall of 2024, the Workgroup is working on plan designs for 2026. The DC Health Exchange Authority must evaluate the Workgroup's recommended designs against the AV calculator to finalize them. In this process, we sometimes discover significant shifts caused by the calculator update. For example, with no changes, the DC Health Link standard plans from 2025 at all metal levels are out of compliance under the 2026 calculator. We began considering changes in mid-September. This timeline is needed in other state marketplaces as well, such as Covered California and their standardized benefit designs. **Therefore, it is essential to have a draft AV calculator by early fall, 15 months prior to a plan year, and a final calculator no later than 12 months preceding the plan year to assure that state-based exchanges' standardized plan designs comply with required AV levels.**

Recommendations for Network Adequacy

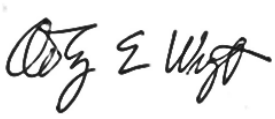
45 CFR 156.230 outlines network adequacy standards for exchange plans which are further delineated in annual guidance. We recommend several changes to these standards in forthcoming rules and guidance, particularly regarding services that affect maternal and child health:

- **Further limit wait times for obstetrics and gynecological care.** We are concerned that current guidance in the 2023 and 2024 Final Letters to Issuers allows wait times of up to 30 days for nonurgent specialty care and does not explain when obstetrics and gynecological care is urgent. That time frame should be further shortened for obstetrics and gynecological care, particularly for pregnancy related care.[xx] In Medicaid managed care, the standard for obstetrics and gynecological care under 42 CFR 438.68 is no longer than 15 days from the date of request.
- **CMS, states, and issuers should consider additional ways to integrate midwifery care into reproductive care in provider shortage areas**. Despite some improvement in 2022, maternal mortality rates remain unacceptably high in the United States[xxi] and many women lack timely access to reproductive care.[xxii] Midwives can help fill in gaps in reproductive care.

- **Standards should specifically address access to pediatric behavioral health.** Current standards do not separately examine adult and pediatric services for behavioral health, though children and young adults often require pediatric providers and age-appropriate facilities.
- **Plans with inadequate networks should be explicitly required to arrange for timely care for enrollees and publish their arrangements on their websites as well as in reports to regulators.** Rules at 45 CFR 165.230 (a)(2)(ii) currently require QHPs that do not satisfy network adequacy standards to describe "how the plan's provider network provides an adequate level of service and will be strengthened…." **In addition, QHP enrollees should have a right to enroll in a different plan outside of the open enrollment period if they learn after enrolling that their own plan does not have an adequate network.** [xxiii]
- **Besides providing access to an up-to-date provider directory, on request, plans should assist enrollees in locating providers with available appointments**. Plans should assist enrollees who have urgent needs, including for behavioral health and obstetrics and gynecological services. Further, plans should assist enrollees in finding providers that speak their languages and that best accommodate their physical disabilities. They should provide and help members locate services such as peer support, doulas, and community health workers.

Thank you again for the chance to comment on proposed improvements to health insurance marketplace regulations and oversight for 2026. Please contact Cheryl Fish-Parcham, Director of Private Coverage at Families USA, cparcham@familiesusa.org, with any questions.

Sincerely,



Anthony Wright
Executive Director

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[i] Marketplace 2024 Open Enrollment Period Report: Final National Snapshot, https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-final-national-snapshot, January 24, 2024.
[ii] Sara R. Collins, Shreya Roy, and Relebohile Masitha, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer — Findings from the Commonwealth Fund 2023 Health Care Affordability Survey* (Commonwealth Fund, Oct. 2023). https://doi.org/10.26099/bf08-3735
[iii] Aubrey Winger, et al, "How financially vulnerable are people with medical debt?" Peterson-KFF Health System Tracker, February 12, 2024, https://www.healthsystemtracker.org/brief/how-financially-vulnerable-are-people-with-medical-debt/#Adults%20with%20medical%20debt%20are%20more%20likely%20to%20seek%20loans%20from%20expensive%20sources,%202021.
[iv] Karen Pollitz, et al, "Claims Denials and Appeals in ACA Marketplace Plans in 2021, Kaiser Family Foundation," February 9, 2023 (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/).
[v] Marketplace Affordability Project, *Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges,* Center on Budget and Policy Priorities, April 10, 2024, https://www.cbpp.org/sites/default/files/4-10-24health.pdf.
[vi] https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity
[vii] US Government Accountability Office, *Private Health Coverage: Results of Covert Testing for Selected Sales Representatives Listed on Healthcare.gov*, **GAO-21-568R,** Published: Aug 10, 2021, https://www.gao.gov/products/gao-21-568r.
[viii] Julia Applebee, "When Rogue Brokers Switch People's ACA Policies, Tax Surprises Can Follow," KFF Health News, April 15, 2024, https://kffhealthnews.org/news/article/aca-obamacare-plans-unauthorized-enrollment-tax-problems/.

[ix] Khanijahani A, Akinci N, Iezadi S, Priore D. Impacts of high-deductible health plans on patients with diabetes: A systematic review of the literature. Prim Care Diabetes. 2021 Dec;15(6):948-957. doi: 10.1016/j.pcd.2021.07.015. Epub 2021 Aug 13. PMID: 34400113.

[x] Sanford Health Plan, Montana Health Co-Op v United States, https://affordablecareactlitigation.com/wp-content/uploads/2020/08/fc-sanford-hp-montana-hco-opinion.pdf, August 14, 2020 [citation format?]

[xi] David Anderson, et al, "Implications of CMS Mandating a Broad Load of CSR Costs," Health Affairs Forefont, May 15, 2018, https://www.healthaffairs.org/content/forefront/implications-cms-mandating-broad-load-csr-costs.

[xii] Stan Dorn, "Silver Linings for Silver Loading," Health Affairs Forefront, June 3, 2019, https://www.healthaffairs.org/content/forefront/silver-linings-silver-loading

[xiii]Stan Dorn and Timothy Jost, "ACA Metal-Tier Mispricing: Improving Affordability by Solving An Actuarial Mystery," https://www.healthaffairs.org/content/forefront/aca-metal-tier-mispricing-improving-affordability-solving-actuarial-mystery?utm_medium=social&utm_source=linkedin&utm_campaign=forefront&utm_content=dorn

[xiv] 28 Tex. Admin. Code §3.505, adopted June 10, 2022.

[xv] New Mexico Office of Superintendent of Insurance, "2024 Plan Year Individual and Small Group Market Rate Filing Guide, 2024py-qhp-issuer-rate-guidance.pdf

[xvi] Jacquieline Lee, et al, Lewis and Ellis presentation to the Green Mountain Care Board, "Cost Sharing Reductions and Silver Loads," February 14, 2024, Cost Sharing Reductions and Silver Loads (vermont.gov); Vermont Green Mountain Care Board, "Guidance on Silver Loading," Effective March 8, 2024, https://ratereview.vermont.gov/sites/dfr/files/documents/2024%20Guidance%20on%20SIlver%20Loading.pdf.

[xvii] https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4298&ChapterID=22

[xviii] https://idoi.illinois.gov/content/dam/soi/en/web/insurance/reports/reports/premium-misalignment-analysis.pdf; Illinois Public Act 103-0650, HB5395, Sec. 355 (c-5), https://www.ilga.gov/legislation/publicacts/103/PDF/103-0650.pdf.

[xix] Op cit.

[xx] See OIG report, "States Could Better Leverage Coverage and Access Requirements to Promote Maternal Health Care Access in Medicaid Managed Care," September 2024. The same principals apply to marketplace plans.

[xxi] Donna Hoyert, Maternal Mortality Rates in the United States, 2022, CDC, https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.pdf/

[xxii] Commonwealth Fund, 2024 State Scorecard on Women's Health and Reproductive Care, July 18, 2024, https://www.commonwealthfund.org/publications/scorecard/2024/jul/2024-state-scorecard-womens-health-and-reproductive-care.

[xxiii] There is a right to join a different plan in Medicaid managed care. See Sabrina Corlette, et al, Access to Services in Medicaid and the Marketplaces, Robert Wood Johnson Foundation, March 1, 2022.