November 12, 2024

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health & Human Services

Dr. Ellen Montz
Deputy Administrator & Director, Center for Consumer Information & Insurance Oversight
Department of Health & Human Services

Attention: CMS-9888-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Submitted via regulations.gov.

RE: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program"

Dear Administrator Brooks-LaSure and Director Montz,

United States of Care (USofCare) is pleased to submit comments in support of the proposed rule by the Centers for Medicare & Medicaid Services (CMS) entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program."

USofCare is a nonpartisan, nonprofit organization working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. We uplift the voices of people whose perspectives on their experiences with the health care system shape our advocacy work. Through our work in the states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels.

Thanks to actions taken by this administration, marketplace coverage remains more affordable and accessible than ever before. People eligible for Enhanced Premium Tax Credits (ePTCs) on the Exchange save, on average, approximately $700 in premium costs. These savings disproportionately benefit underserved communities, including Black and Latino people, who made up a majority of marketplace enrollees for the first time last year. In addition, because of new regulations supported by USofCare, Deferred Action for Childhood Arrivals (DACA) recipients are now eligible to purchase coverage on the exchange and obtain ePTCs to make this coverage more affordable.

The 2026 Notice of Benefit & Payment Parameters (NBPP) proposed rule builds upon these strong consumer and equity protections to ensure that everyone has access to comprehensive, affordable health care as a way to eliminate systematic disparities. As we consider policy solutions to drive health equity, we must continue to center the needs of individuals and communities that face the greatest barriers to accessing and utilizing health care. As such, USofCare appreciates the priorities put forth in the proposed 2026 NBPP, focusing our comments on:

I. **Promoting Affordable Coverage**
II. **Ensuring Comprehensive, Equitable Care**
III. **Improving the Consumer Experience**
IV. **Improving Marketplace Operations**

Promoting Affordable Coverage

Our listening work demonstrates that people rank affordability as their top concern with the health care system. As health care prices rise – in large part due to decades-long industry movement towards consolidation – people hold off on seeking needed care because they can't afford it. In fact, over half of U.S. adults report having to delay or skip care due to cost. What's more, 41% of U.S. adults reported having some form of medical debt in 2022, an issue that is particularly prevalent among Black and Latino communities. Cost-sharing, even as little as a dollar, has been shown to deter people from seeking the care they need. To that end, we are encouraged to see CMS prioritize taking action to promote affordability and lower the cost of coverage for people.

Silver Loading

Since the previous administration's decision to end the Affordable Care Act's cost-sharing reduction (CSR) payments, issuers have pursued silver loading to ensure costs remain low for people. **While we understand issuers have the authority to continue this practice without explicit CMS rulemaking, we are supportive of efforts by CMS to establish the practice via regulation,** especially given the number of questions CMS has received specifically related to the plan-level adjustment process that permits silver loading. Should CMS choose to codify silver loading, we urge the agency to pursue solutions that keep people's out-of-pocket costs low and secure changes that don't inadvertently undermine some of the ACA's core consumer protections. Given states' traditional management of the rate setting process, we recommend changes to ensure that plan-level adjustments permitted for the "actuarial value and cost-sharing design of the plan" include adjustments for CSRs if not otherwise reimbursed. We urge CMS to permit a health insurance issuer to vary premium rates for a particular plans from its market-wide index rate for a relevant state market based only on the actuarial value and cost-sharing design of the plan, including cost-sharing reductions.

Furthermore, many states, including New Mexico and Texas, continue to pursue innovative solutions to address the effects of the elimination of CSR payments with great success, from shifting people from high- to low-deductible plans to increasing the total number of people enrolled in the marketplace overall. Should it move to codify the silver loading process, we encourage CMS to avoid language that may, inadvertently or otherwise, limit these state flexibilities, roll back this progress, or undermine state methodologies to lower the cost of care.

Moving forward, we encourage CMS and CCIIO to continue to engage with stakeholders to ensure that people's out-of-pocket costs remain low when considering any changes to federal guidance or regulation on silver loading.

User Fees

USofCare strongly supports making permanent the Enhanced Premium Tax Credits (ePTCs) first established by the American Rescue Plan Act of 2021 and extended by the Inflation Reduction Act of 2022. These subsidies allow certain populations who were previously ineligible for premium tax credits to access more affordable care. An estimated 3.8 million people have benefitted from ePTCs, with the average enrollee saving $700 in 2024. Currently, ePTCs are set to expire on December 31, 2025, unless Congress acts to extend them or make them permanent.

Should these tax credits expire, premiums are expected to increase steeply for everyone across the board, despite average monthly premiums being 32% lower in 2024 than in 2021 due to ePTCs. Failure to extend these subsidies would also reverse important gains in health equity, as ePTCs yielded greater gains in coverage for Black and Hispanic people compared to their white counterparts.

> *"I know people who are making $50,000 a year, that sounds like a decent amount of money, but they still can't afford to live. And then you have inflation on top of that, and you don't qualify for SNAP or any type of assistance. But at the same time, you can't afford anything. So, people don't seek health care, because they can't afford the copays or can't afford the bills yet."*
> *~ Black woman, South Carolina*

Congressional inaction has also resulted in challenges for states and State-Based Exchanges (SBEs). The uncertainty surrounding ePTCs could impact states' ability to receive pass-through funding or administer their Basic Health Programs (BHPs), which are funded by revenue streams tied to these subsidies, such as Oregon's OHP Bridge Plan, which uses pass-through funding to provide affordable coverage to people with incomes between 138-200% of the FPL. Commonwealth Fund analysis has demonstrated that even states with BHPs and generous coverage plans cannot avoid coverage losses should the ePTCs expire, which makes extending these subsidies all the more important.

As stated in the proposed rule, Congressional inaction on this topic also has direct implications for the Marketplace. People will encounter significantly higher user fees in these circumstances, with monthly premiums for State-Based Exchanges using the Federal Platform (SBE-FP) being raised to 2% and monthly premiums for those using the Federally-Facilitated Exchange (FFE) being raised to 2.5%. However, should Congress extend ePTCs, user fees will be raised to a range of 1.8% to 2.2% of monthly premiums for FFEs and a range of 1.4% to 1.8% of monthly premiums for SBE-FPs, which are closer to the user fees for plan year 2025.

Within the proposed rule, CMS seeks comment regarding the appropriateness of a March 31, 2025 deadline for Congress to act on ePTCs before user fees are raised. As the March 31 deadline is only a few months into the new Congressional session and new presidential administration, we believe that Congress may need a few more months in order to come to a decision regarding ePTCs. However, we also understand that states need to have an adequate amount of time and resources in order to operate their plans. As all states must submit their rate findings by August 2025, **we recommend that CMS adjust their deadline for Congressional action to May 31, 2025 to allow for increased flexibility** while still allowing states three months to make any necessary adjustments.

Updating Premium Payment Thresholds to Permit Fixed or Premium-Percent Thresholds

Currently, if a consumer does not pay the full portion of their premiums owed, they can be placed into a grace period. If the consumer has not paid the full premium amount by the end of their grace period, their coverage can be terminated, regardless of if the amount owed is large or small. As noted within the proposed rule, over 184,000 people lost their coverage in 2023 – 12.24% of all non-payment determinations that year – despite the fact that they only owed $10 or less. **USofCare agrees with the Agency's rationale that missing the threshold by small-dollar amounts does not justify termination of coverage,** and that premium payment thresholds alone are not sufficiently flexible enough to permit issuers to not terminate an enrollee's coverage in these circumstances.

Because of this, USofCare is supportive of the proposal to update premium payment thresholds to allow both fixed-dollar and reasonable premium-percent thresholds. We appreciate the proposed fixed-dollar premium payment threshold of $5, as it will result in fewer people losing coverage because they only owed a few dollars. However, USofCare urges for the fixed threshold to be increased to at least $10. According to CMS's own calculations, the number of people (102,728) whose coverage was terminated in 2023 for owing amounts of $5.01 to $10 exceeded the number of people (81,383) whose coverage was terminated in 2023 because they owed $5 or less. Raising this limit by only a few dollars could prevent termination of coverage for more than double the amount of people, while still preventing people from accumulating excessive debts and permitting flexibility for issuers.

> *"I didn't have insurance, and my care costs, like the medication I take, one dose of it is around $5,000. So it wasn't that I wanted to pay that; I didn't have a choice. I could have bankrupted myself trying to get treatment. So, you try to go without it. You try to avoid needing any kind of care."*
> *~ White man, New York*

CMS should consider making additional updates to the proposed new options for payment thresholds to avoid subjecting them to restrictions that would limit their value. The thresholds should be allowed to apply to binder payments; currently, the proposal would not apply to the millions of people who have a $0 monthly premium thanks to ePTCs, but would apply to consumers who owe a premium of $1. Within the proposed rule, CMS notes that the one-threshold limit helps prevent "complex situations" that could occur if multiple thresholds are used. CMS should further clarify what this refers to, as they should permit issuers with the flexibility to offer multiple thresholds as opposed to just one, which may help consumers avoid losing their coverage.

Navigators & Medical Debt Assistance Programs
While we support CMS' efforts to help the nearly 20 million people living in the U.S. with medical debt, we are concerned about the capacity for navigators and others providing consumer assistance to provide this support given existing responsibilities.

If this proposal is finalized, **we urge CMS to provide additional funding and resources to these programs, including issuing guidance and provide training for Navigators to better understand these programs and ensure that consumers are directed to legitimate assistance** rather than illegitimate "financial assistance programs" that take advantage of vulnerable consumers. In fact, 82% of people across the country across demographics, income levels, and partisan affiliations support increased availability of navigators. As such, we appreciate the Administration's commitment to funding navigator programs and encourage further investment.

Additionally, CMS should explore other avenues to provide people with needed information on medical debt assistance programs beyond navigators including community health workers and other community-based partners that are able to effectively "meet people where they are."

Ensuring Comprehensive, Equitable Care
In addition to being affordable, people's care must be comprehensive and encompass all of their health care needs. Because of this, we applaud the provisions within the proposed rule that ensure sufficient and timely access to providers in their communities, support continuity of care,

and improve health outcomes. Furthermore, we appreciate the focus of the proposed rule on improving health equity and eliminating health disparities.

Essential Community Provider Network Adequacy Enforcement
Comprehensive network adequacy requirements to improve access to essential community providers (ECPs), such as federally qualified health centers (FQHCs) and substance use disorder (SUD) treatment centers, allow low-income people and other underserved populations to access needed services in-network. USofCare has strongly supported now-finalized rules to expand the definition of ECP to include additional providers, such as family planning providers, and to increase the percentage of ECPs in a plan area required to be included in plans in states using the federal platform.

Thanks to improvements to its data collection systems, CMS is now able to conduct its own oversight of ECP requirements compliance. Given patchwork state-level enforcement of these requirements, **USofCare strongly supports increased federal oversight through plan reviews to ensure ECP consistency across states and promote health equity.** At the same time, we know that through our listening work and current research that despite existing network adequacy standards, many networks remain narrow and may not fully serve the needs of people enrolled, particularly amongst low-income and medically underserved groups. As we have argued in previous comments, we strongly encourage CMS to consider raising the current 35% ECP threshold to ensure that all people – regardless of race, ethnicity, language, disability status, or other status – have access to care from a provider network in a care setting that reflects the diversity and lived experience of the community it serves.

Our recently released policy principles on high-quality, cost-effective services and research report on Colorado's innovative culturally responsive care networks highlight how Colorado's "Colorado Option" standardized benefit plan can provide a template for action. In addition to requiring plans to include at least 50% of ECPs within a plan's service area, these networks also include doulas, midwives and other care providers that we know have the potential to reduce disparities, particularly among Black women who are nearly three times more likely to die of pregnancy-related causes than white women.

Risk Adjustment
HHS has long worked with plans and other stakeholders to ensure that risk adjustment methodologies and policies ensure that all people, no matter their health status, have access to quality, affordable insurance. Historically, HHS has relied on two types of diagnosis criteria to model patients' risk scores that inform its risk adjustment policies. While we support this criteria, it doesn't take into account other factors that may influence risk scores unrelated to a specific diagnosis, such as HIV prevention medication, or pre-exposure prophylaxis (PrEP).

PrEP has been proven to be an extremely effective medication to prevent HIV transmission and is required to be covered by private health plans without cost-sharing thanks to the ACA's preventive services mandate. Unfortunately, the high cost of PrEP also poses challenges for uninsured populations and may affect insurers' decisions to restrict certain forms of coverage and access to care through prior authorization and other utilization management processes. **We are pleased to see CMS introduce a new class of risk factor criteria known as affiliated cost factors (ACFs) to account for receipt of PrEP and other non-diagnostic criteria to account for the additional costs they impose on issuers.** Despite its effectiveness, PrEP uptake remains low even amongst high-risk populations, including Black and Latino men who have sex with men (MSM). We are hopeful that changes to

the risk adjustment methodologies to account for things like PrEP will remove some of these barriers to coverage.

Unfortunately, significant legal uncertainty surrounding cost-free access to preventive care exists because of the ongoing *Braidwood Management, Inc. v. Becerra* court case. We are hopeful that efforts to strengthen risk adjustment policies that include PrEP and other similar treatments will encourage issuers to maintain cost-free coverage of these services, even if the no-cost preventive service mandate is restricted or removed in full by the courts. People have come to rely on these treatments, and any re-imposition of cost-sharing could lead to significant rollbacks in coverage and an estimated 2,000 new HIV infections annually.

Improving the Consumer Experience

USofCare knows from our listening work that people aren't just worried about affording their care – they also want their coverage to be understandable and dependable. The sheer complexity of the system can be overwhelming, which is why we appreciate the steps that CMS outlines within the proposed rule to simplify plan options for people and bolster consumer protections within the Marketplace.

Updating Standardized Plan Options and Non-Standardized Plan Option Limits

We know from our listening work that people want to understand their health care, yet far too often many people just feel overwhelmed by too many health care plan choices, which reached an average of 92 plans per consumer in 2024. Because of this, USofCare has supported CMS's efforts in recent years to simplify consumer choice and improve the plan selection process by limiting the number of non-standardized plans issuers can offer and requiring issuers to offer at least one standardized plan option at every metal level with defined actuarial values (AVs) and uniform cost-sharing requirements and deductibles. The success of this approach has shown up in states, including Colorado, where nearly twice as many people enrolled in the state's Colorado Option standardized plans in 2024 compared to the previous year. These plans, offered at every metal tier and in every county in the state, include benefit packages structured to make health care more affordable for people, including free primary care and mental health care visits.

Unfortunately, since a provision requiring standardized plans to be "meaningfully different" was removed in 2019, a number of largely identical standardized plans has sprung up and caused confusion amongst consumers. To cut down on these similar plans, CMS proposes to reintroduce the "meaningfully different" standard for issuers with more than one standardized plan with the same product network type, metal level, and service area. **USofCare supports this meaningfully different standard, which will cut down on indistinguishable plans and ensure that those offered offer clear differences in benefit design and/or provider networks** while still satisfying basic, standardized requirements.

At the same time, we have concerns that the meaningful difference standard as currently structured may still allow issuers to offer two or more plans that may be all but identical aside from small differences in benefit design, provider network, or other metric. While we appreciate that CMS will monitor issuers' offerings to assess compliance with the reintroduced meaningful difference standard, **we encourage the agency to provide more clarity, potentially through sub-regulatory guidance, on what constitutes a meaningful difference between health plans.** Further clarification from CMS would improve the consumer experience and lead people to make more informed choices when choosing what's best for themselves and their families.

Failure to Reconcile Process & Timeliness Standards

More than 19 million people across the country have depended on advance premium tax credits (APTCs) in order to afford their coverage. As APTCs are integral to helping people pay for the care they need, it is critical that they are calculated and communicated to consumers accurately and efficiently.

Currently, Marketplaces must inform consumers about the potential to lose their APTCs due to "Failure to Reconcile" (FTR) rules. This means that a consumer will lose their APTC if they fail to reconcile it on their tax returns for two consecutive years. Under the proposed rule, Marketplaces may provide warning to consumers who have filed and failed to reconcile for two years, either through a direct notice to the taxpayer that demonstrates their FTR status, or through a general notice that explains FTR rules and warns of loss without a specific reason. USofCare is supportive of these updates, but urges CMS to think carefully about how to more comprehensively address issues with consumer understanding and ability to resolve FTR issues. While the notices do provide clarity, they may not provide the specific reason why the consumer is at risk of losing APTC or may not arrive in a timely manner. As such, **we encourage CMS to streamline FTR processes in order to provide consumers with specific, timely information about their coverage, and ask the agency to consider eliminating FTR rules altogether as they are a regulatory creation without statutory basis.**

Further, as APTC payments are calculated using enrollment data provided by State Exchanges, it is critical that any data inaccuracies are resolved efficiently, and a robust timeframe, procedure, and exceptions process to accomplish this is critical. Because of this, **USofCare is supportive of the 60 calendar day window and timeliness standards within the proposed rule for State Exchanges to resolve enrollment data inaccuracies from issuers operating on their platforms.** Doing so will minimize the impacts on a consumer's APTC payment should it be calculated using inaccurate data, and will also allow for greater certainty from State Exchanges and alignment with previous HHS guidance.

Strengthening Transparency & Consumer Protection in the Marketplace

USofCare supports proposals within the 2026 NBPP to increase transparency and protect consumers in the Marketplace. We applaud the proposal to publish aggregated, summary-level Quality Improvement Strategy (QIS) data on an annual basis, which will not only allow for greater access to information, but greater understanding of how issuers can improve the quality of coverage through best practices. Further, we appreciate the proposal to publish SBE Annual Reporting Tools and related audits for SBEs and SBM-FPs on a yearly basis. These data points should be published in a way that is easy for consumers to understand, in multiple languages, and available on a centralized platform or website for straightforward access.

> *"All people want the same thing, they want to feel good. They want to think clearly. They want to face the sun of the following day as best they can. We're people. We don't need to be scared into doing something. We don't want to be pushed into doing something. We want to trust that you have our best interests at heart. Not the insurance company, not the hospital, not the system, but our best interests."*
> *~ Black woman, South Carolina*

USofCare appreciates the proposed updates to the Model Consent Form to make it more understandable for enrollees and to ensure documentation of the consumer consent that agents, brokers, and web-brokers are required to obtain before they assist with enrollment. Providing brokers with scripts regarding the consent requirements will ensure that consumers are given accurate, understandable, and consistent information. We agree with the Agency's rationale that

this will not only improve marketplace transparency and reduce the potential for financial errors, but also will help ensure accountability for when CMS adjudicates disputes between consumers and agents, brokers, and web-brokers.

USofCare commends the provisions within the proposed rule that permit CMS the authority to conduct compliance reviews and pursue enforcement mechanisms in order to prevent unauthorized Marketplace activities among agents and brokers. **Specifically, we support that should a broker pose an "unacceptable risk" to the Marketplace, CMS has the authority to suspend their ability to engage in Marketplace transactions. At the same time, CMS should clarify that if a broker is suspended from the FFM, they must also be suspended from SBMs.** As a suspended broker is not barred from continuing to provide enrollment assistance, we ask that CMS require suspended brokers to disclose as such to current and prospective clients and provide them with accurate model language to be able to do so accurately. CMS should also share information, such as the National Producer Numbers and reason for suspension of any suspended broker, to state Departments of Insurance to support further oversight efforts. Doing so will bolster accountability for non-compliance, promote program integrity, and protect consumers.

Improving Marketplace Operations

Finally, we know that actions can be taken to increase the efficiency and effectiveness of the marketplaces for both people and issuers. As CMS considers changes to marketplace operations, we encourage the agency to prioritize changes that benefit people and ensure their perspectives are heard.

Actuarial Value Calculator

Since the passage of the ACA, plans have used the Actuarial Value Calculator (AVC) to design plans that adhere to requirements for various metal levels of coverage. We appreciate CMS' **proposal to release the AVC earlier so stakeholders have more time to consider changes, and urge CMS to continue releasing a draft of the AVC before the final version is released. At the same time, we encourage CMS to establish processes to ensure a wide range of perspectives are taken into account when updates to the AVC are made**, such as those from Navigators, community-based organizations, patients, and others.

Conclusion

Thank you for the opportunity to respond to the proposed 2026 Notice of Benefit & Payment Parameters, which builds towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care. Please reach out to Eric Waskowicz, Senior Policy Manager, at ewaskowicz@usofcare.org, and Orla Levens, Federal Policy & Government Affairs Coordinator, at olevens@usofcare.org with any questions.

Sincerely,

Lisa Hunter (she/her)
Senior Director for Policy & External Affairs
United States of Care