January 30, 2023

Submitted via regulations.gov

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-8016

**Re: RIN 0938–AU97; CMS–9899–P**
**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024**

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide these comments on the Department of Health and Human Services' (HHS) proposed rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 (hereinafter "NBPP 2024 Proposed Rule").

Please also note our objection to the forty-five day comment period, which is insufficient for such a complex and far-reaching rulemaking. Accordingly, NHeLP's comments herein largely focus on actual regulatory proposals in the NBPP 2024 Proposed Rule, and do not address HHS's various queries on possible future rulemaking.

## I. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

### A. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

We welcome HHS's proposal to strengthen the Navigator program in the NBPP 2024 Proposed Rule.[1] The Affordable Care Act (ACA) created the Navigator program to provide outreach, assistance and education to consumers seeking health insurance through the ACA Marketplaces. Navigators provide free, unbiased, and comprehensive information about health coverage. Evidence shows that consumers find the process of searching for and keeping health insurance overwhelming, and highly value the assistance they receive from Navigators.[2]

Evidence also shows that millions of people find the process of applying for and using health insurance overwhelming.[3] Many lack basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including Black, Indigenous, and other People of Color (BIPOC).[4] Navigators also play a key role in enrolling people in Medicaid and the Children's Health Insurance Program (CHIP).

However, despite the vital role Navigators play, the previous administration cut the program. Between 2016 and 2020, program funding was slashed by eighty-four percent and the number of grantees cut in half.[5] It left at least one state without any navigators and

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[1] U.S. Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2024 Proposed Rule*, 87 Fed. Reg. 78206-78322 (Dec. 21, 2022), https://www.govinfo.gov/content/pkg/FR-2022-12-21/pdf/2022-27206.pdf.

[2] Karen Pollitz et al., *Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need,* Kaiser Family Foundation (Aug. 7, 2020), https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-rief/.

[3] *Id.*

[4] Jean Edward et al., *Availability of Health Insurance Literacy Resources Fails to Meet Consumer Needs in Rural, Appalachian Communities: Implications for State Medicaid Waivers*, 37 J. RURAL HEALTH 526, 531-3 (June 25, 2020), https://onlinelibrary.wiley.com/doi/full/10.1111/jrh.12485; Victor G. Villagram et al., *Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference*, 25 Am. J. Managed Care (Mar. 7, 2019), https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference.

[5] Katie Keith, *Marketplace Enrollment Tops 12 Million For 2021; Largest-Ever Funding For Navigators*, Health Affairs Blog (Apr. 22, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210422.65513/full/.

left large regional gaps in other states.[6] Millions of people looking for assistance with enrollment reported being unable to find help. Several states also reported that funding cuts limited outreach to rural communities and to Black and Latinx populations.[7] We welcomed HHS's increase in Navigator funding to $98.9 million for the 2022 plan year.[8] The investment in the Navigator program has led to record Marketplace enrollment and historic lows in the number of people without insurance.[9]

We have qualified support for HHS's proposal to end the prohibition on door-to-door outreach. Face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of applying, selecting a plan, resolving data matching inconsistencies, and assisting with appeals. In-person assistance is especially critical in rural and underserved communities where people may not have reliable access to a computer or telephone. Door-to-door outreach will bolster efforts to enroll the remaining, hard-to-reach individuals, families, and communities who are eligible for insurance affordability programs, but unenrolled.

Door-to-door outreach underscores the need to ensure that program workers are adequately trained and culturally competent to serve their communities. HHS should also ensure that Navigator programs meet their obligations under federal law to persons with limited English proficiency (LEP) and persons with disabilities.

Allowing Navigators to cold-call prospective enrollees and conduct door-to-door outreach may also help counter brokers, marketers, and fraudsters who engage in direct outreach and steer uninsured persons to junk products like short term, limited duration (STLD) plans and Health Sharing Associations and other health plans and insurance-like products that do not comply with key ACA protections including Essential Health Benefits (EHBs).[10]. It may also open the door to identity theft or other criminal acts.

Moreover, we urge HHS to restore the requirement, which it eliminated in the 2019 NBPP Final Rule, to have at least two in-person Navigator organizations in each state and to

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[6] Karen Pollitz & Jennifer Tolbert, *Data Note: Limited Navigator Funding for Federal Marketplace States*, Kaiser Family Found. (Oct. 13, 2020), https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/.
[7] Olivia Hoppe & JoAnn Volk, *Affordable Care Act Navigators: Unexpected Success During 2018 Enrollment Season Shouldn't Obscure Challenges Ahead,* Georgetown University Health Policy Institute, Center on Health Insurance Reforms (Jan. 12, 2018).
[8] U.S. Dept. of Health & Human Srvs., *Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of HealthCare.gov Open Enrollment Period* (Aug. 26, 2022), https://www.hhs.gov/about/news/2022/08/26/biden-harris-administration-makes-largest-investment-ever-in-navigators-ahead-of-healthcare-gov-open-enrollment-period.html.
[9] Ctrs. for Medicare & Medicaid Srvs., *Marketplace 2023 Open Enrollment Period Report: National Snapshot #3* (Jan. 11, 2023), https://www.cms.gov/newsroom/fact-sheets/marketplace-2023-open-enrollment-period-report-national-snapshot-3.
[10] Leukemia and Lymphoma Society (LLS) et al., *Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed* (March 25, 2021), https://www.lls.org/sites/default/files/National/undercovered_report.pdf.

ensure that at least one of those organizations was a trusted community nonprofit.[11] Consumer-focused nonprofits are often best positioned to serve as Navigator entities because they are often well-established trusted entities in their local community. They are uniquely positioned to provide outreach to high-need communities in their area.

B. 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)

NHeLP strongly supports robust standards and accountability measures for agents, brokers and web-brokers. As a recent report from the Leukemia and Lymphoma Society and approximately thirty other patient advocacy organizations exposed, web brokers often steer consumers to STLD plans, Health Sharing Associations, and other noncompliant plans and products.[12] In fact, a recent Government Accountability Office (GAO) secret shopper report found that in over a quarter of the secret shopper calls, sales representatives attempted to sell non-compliant health coverage and engaged in such misleading and deceptive sales tactics that the GAO referred the sales representative to the Federal Trade Commission for further investigation.[13]

NHeLP supports the proposed changes at § 155.220, which implement new procedures and consumer protection standards for agents, brokers, and web-brokers that assist consumers with enrollments through federal facilitated exchange (FFE) and state-based exchanges that use the federal platform (SBE-FPs). Specifically, we agree with HHS's proposed changes at § 155.220(g)(5)(i)(B) and § 155.220(h)(3) to provide HHS more time to review suspension rebuttal evidence and termination reconsideration requests that agents, brokers, and web-brokers submit to HHS.

We believe it is prudent to allow HHS forty-five calendar days to respond to evidence the agent, broker, or web-broker submits to rebut the allegations that they engaged in fraud or abusive, and sixty calendar days to review cases of agent, broker, or web-broker non-compliance where the license was terminated. These longer timelines will allow HHS sufficient opportunity to adequately review complex inquiries that require more HHS resources and time. Since these are maximum timeframes, HHS could still complete the review of cases that do not involve a large number of alleged violations or impacted consumers in a shorter timeframe.

NHeLP welcomes the proposed changes that require agents, broker, and web-brokers to document that the applicant's eligibility information has been reviewed by, and confirmed to be accurate by, the applicant or their authorized representative, before the application is

[11] U.S. Dept. of Health & Human Srvs., Notice of Benefit and Payment Parameters for 2019 Final Rule, 83 Fed. Reg. 16930 – 17070 (April 17, 2018), https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf.
[12] See LLS, note 10 *supra*.
[13] U.S. Gov't Accountability Office, *Private Health Coverage: Results of Covert Testing for Selected Offerings,* (Aug. 24, 2020), https://www.gao.gov/assets/710/709009.pdf.

submitted. We also support the proposed change that the consumer, or their authorized representative, has to take an action, such as providing a signature or recorded verbal confirmation, to document the consent.

Absent documentation, an agent, broker, or web-broker could fabricate the record and state they received consumer consent when they did not. We also agree that agents, brokers and web-brokers must maintain the verification documentation for a minimum of ten years. This provides HHS sufficient time to audit agents, brokers and web-brokers pursuant to existing § 155.220(c)(5), and make sure they are adhering to these consumer consent requirements. These additional safeguards will help reduce the number of inaccurate eligibility determinations, and the number of consumers who receive the incorrect amount of Advance Premium Tax Credits (APTCs), which in some cases results in high tax liability for the consumer.

Although we agree that HHS should not prescribe the method(s) for agents, brokers, and web-brokers to document the consumer's consent, we do think they should be required to offer consumers multiple different verification options so that the verification process does not unnecessarily exclude consumers from coverage. For example, if an agent only accepts verification by a consumer creating an account and signing through the agent's online portal, but the consumer does not have a computer, this is a barrier to coverage.

HHS should consider expanding the use of consumer consents to protect health care consumers. California's Marketplace, Covered California, requires Covered California Certified Insurance Agents (CIAs) to obtain a Consumer Acknowledgment and Full Disclosure Form from each consumer who purchases a Health Sharing Associations product.[14] The policy requires agents to disclose the consumer's Marketplace enrollment options to them before enrolling them in a Health Sharing Association product, keep a record of the signed form for three years, and disclose the number of Health Sharing Associations sold in the prior year to Covered California.[15] HHS should lift up these best practices and consider requiring agents, brokers and web-brokers selling products through the FFE and SBE-FPs to adhere to these acknowledgment and disclosure requirements.

Overall, NHeLP supports monitoring and oversight of all agents, brokers and web-brokers to ensure they are acting scrupulously and well serving consumers. HHS should confirm that all web-brokers are adhering to approved application questions and flows, providing accurate eligibility assessments (including for Medicaid and CHIP, complex households like those with more than two adults, with mixed immigration status, and American Indians/Alaska Natives), providing appropriate consumer support, displaying all information fully and accurately, and complying with privacy and security standards via regular audits.

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[14] Covered Cal., *HCSM Disclosure Forum* (Nov. 2019), https://board.coveredca.com/meetings/2019/11-21%20Meeting/Background/HCSM%20Disclosure%20and%20Table.pdf.

[15] Covered Cal., *HCSM Policy and Procedures 11-12-2019* (Nov. 12, 2019), https://board.coveredca.com/meetings/2019/11-21%20Meeting/Background/HCSM%20Policy%20and%20Procedures%2011-12-2019.pdf.

Additionally, HHS should ensure that agents, brokers and web-brokers follow all non-discrimination requirements, including access for LEP consumers and persons with disabilities.

HHS should also require Marketplaces to provide consumer-friendly tools to curtail agent, broker and web-broker misconduct. For example, on Coveredca.com, a consumer can use the "Insurance Finder" tool to search for Covered California certified agents and enrollers. This allows consumers to feel confident they are working with an agent or certified enroller who has been validated by the Marketplace and who will appropriately guide them to the plan selection process.

C. Failure to File and Reconcile Process (§ 155.305(f)(4))

We agree with HHS's goal of promoting continuity of coverage, encouraging compliance with the filing and reconciling requirement, minimizing the potential for APTC recipients to incur large tax liabilities over time and avoiding situations where enrollees become uninsured when their APTC is terminated.[16] However, as we have said in previous comments, the Failure to File and Reconcile (FTR) process continues to violate due process requirements of the U.S. Constitution.[17] The FTR process is plagued with deficiencies, including the information provided in the various FTR notices (which should include an explanation of what the FTR requirement is and consequences to coverage), as well as the reliability of the decision-making process.[18] Although we generally support the proposed rule changes regarding FTR, we again request that HHS fix the constitutional deficiencies in the FTR process. In addition, HHS should neither deny nor terminate APTCs due to FTR until those issues are addressed and fully tested.[19]

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[16] 81 Fed. Reg. 78255.

[17] *See, e.g.,* Nat. Health Law Program, *Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*, 15-17 (Nov. 27, 2017), https://healthlaw.org/resource/nhelp-comments-on-hhs-2019-proposed-rule-change-to-benefit-payment-parameters/ (describing the due process violations with the FTR notices and processes); *see also* NHeLP Letters to CCIIO regarding the FTR process on Aug. 24, 2017 and Oct. 19, 2017 (on file) [hereinafter "NHeLP FTR Comments"]. Based on the information in the preamble, NHeLP is assuming for these comments that the FTR notices have not changed significantly since we last reviewed and commented on them.

[18] *Id*.

[19] U.S. Const. Amend. XIV; *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314-15 (1950) (requiring "notice reasonably calculated, under all circumstances, to apprise intended parties of the pendency of the action and afford them an opportunity to present their objections" and that "[t]he means [of notice] employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it."); *Goldberg*, 397 at 267-68 (requiring "timely" notice "detailing the reasons for a proposed action"); *Mathews v. Eldridge*, 424 U.S. 319, 348 1976) (risk of erroneous deprivation through procedures being used); *Carey v. Quern,* 588 F.2d 230, 232 (7th Cir. 1978) (due process requires the assistance program be administered to insure fairness and avoid risk of arbitrary decision making).

HHS highlights the ongoing problems with the reliability and timeliness of the IRS data in determining whether a person is eligible at the time of the determination for APTCs.[20] If the Marketplace cannot make an accurate determination of ineligibility based on IRS data because that information is not current or is otherwise unreliable, then the Marketplace must not deny APTCs to individuals on such grounds unless the Marketplace can otherwise check the information from reliable sources before sending termination notices. Moreover, those notices must explain, with specificity, the reasons why that individual is having APTCs terminated such that they can understand the bases of the denial and how to appeal a wrongful termination. It is unconscionable that Marketplace continues to terminate individuals using an error-prone system and in violation of core constitutional protections.

The due process failures of the FTR notices is not a new issue.[21] The notices we have reviewed do not provide minimally sufficient information for beneficiaries to understand the why the action is being taken, nor do they have the information they need to access a hearing that will afford them the opportunity to explain why the agency's decision is incorrect.[22] FTR notices do not include the details needed, including financial calculations and household filing information, for denying APTCs.[23] It is simply constitutionally insufficient to provide a list of three potential reasons for the action, only one of much may be true, or to presume the notice recipient has any understanding of what "failure to reconcile" means.[24] This not only leaves the individual guessing as to the reason, it leaves out any relevant financial or tax filer information that may be the reason for the denial.

Predictably, and as HHS has recognized in the preamble to the NBPP 2024 Proposed Rule, this has led to significant confusion from APTC applicants and beneficiaries, not only from the notices but about the requirement overall.[25] This confusion also means that people, including those assisted by third-party tax preparers, are likely not accurately answering the application question regarding ATPC reconciliation.[26] In addition, the problems with data from the IRS, including inaccurate or delayed data, mean that people may have been wrongfully denied their APTCs due to unlawful bad processes. The data cited by HHS regarding the impact of pandemic stays on the FTR process shows how confusing and potentially erroneous the process is, how many people have maintained

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[20] 87 Fed. Reg. 78255-57.
[21] NHeLP FTR Comments, *supra* note 17.
[22] *See, e.g., Goldberg v. Kelly,* 397 U.S. 254 (1970); *Gray Panthers v. Schweiker,* 652 F.2d 146, 168 (D.C. Cir. 1981) (without adequate notice of reasons for denial "hearing serves no purpose.").
[23] *Goldberg*, 397 U.S. at 267-68 (requiring detailed reasons in notice, including "the legal and factual bases"); *see also, e.g., Barry v. Lyon,* 834 F.3d 706, 720 (6th Cir. 2016) (agency must provide "specific, individualized reasons for the agency action"); *Rodriguez v. Chen,* 985 F. Supp. 1189, 1195 (D. Ariz. 1996) (public interest in assuring health benefits will not be erroneously terminated or denied outweighs inconvenience to the state and the notice must include specific financial information where applicable so that errors may be corrected); *Ortiz v. Eichler*, 616 F. Supp. 1046, 1062 (D. Del. 1985), aff'd 794 F.2d 880 (3d Cir. 1986) (requiring notice include what financial information was considered and relevant calculations if calculations of income are involved in the eligibility decision).
[24] *See, e.g., Baker v. State,* 191 P.3d 1005, 1010 (Alaska 2008).
[25] 87 Fed. Reg. 78255-56.
[26] *Id.* at 78256.

coverage, and how important it is to get the process right before beginning to terminate this important benefit again.[27]

We support the proposed change to only determine an individual ineligible for APTCs after two consecutive tax years due to the delays in filing allowed by IRS and by general delays in IRS information. Requiring two consecutive years will help ensure that people are not terminated for non-filing when they may actually still be within a filing period or because the IRS has not yet processed timely submitted information. The disjointed timing of tax filing and APTC determinations means there would be a high risk of erroneous terminations if the FTR were to continue annually.

We also agree that significantly more outreach is needed not only to beneficiaries, but to tax preparers, about the FTR process and the risk of noncompliance. Understandable and accurate information about the process for determining eligibility is critical.[28] The dangers of losing coverage are well documented, as are the impacts of losing APTC coverage and the high risk of not re-enrolling.[29]

While we support the change to two consecutive years and the delay to restarting the FTR process until the IRS can update its systems and HHS can notify beneficiaries of the change, we further ask that the process not be restarted until HHS can provide a constitutionally sufficient FTR process, including notices. Before FTR is ready to relaunch, HHS must test the data exchanges and decision-making processes to ensure that erroneous decisions are not being made and that the data is accurate, timely, and otherwise reliable. In addition, the notices used throughout the process must properly inform beneficiaries of the process, requirements, bases of any decisions (including any relevant financial or household filing data), and process for requesting an appeal. While we recognize that there is also a need to avoid individuals from accumulating significant tax liability, we believe interim processes can be implemented to notify people of the FTR requirement, processes, and consequences.

D. Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320

Applicants and enrollees renewing their coverage can encounter difficulties when their projected annual household income is inconsistent IRS data or when that data is unavailable. HHS now recognizes that, when seeking to resolve data matching issues (DMI), “[t]he current process is overly punitive to consumers and burdensome to

[27] 87 Fed Reg. 78256-57.
[28] *See, e.g., Goldberg,* 397 U.S. at 267-68; *Goss v. Lopez*, 419 U.S. 565, 579 (1975) (due process has little reality or worth unless a person understands the issue is pending); *see also Waldrop v. New Mexico Dept. Hum. Servs. Dep’t,* No. CV 14-047 JH/KBM, 2015 WL 13665460, at *24 (D.N.M. Mar. 10, 2015) (beneficiary must be provided notice about the process).
[29] 87 Fed Reg. 78256-57.

Exchanges."[30] We agree. The lag time in IRS data, plus requiring consumers to document income not yet received, has led some consumers to give up and forgo coverage.

Accordingly, we support HHS's proposal to require Marketplaces to accept an applicant's or enrollee's attestation of projected annual household income when the Marketplace requests IRS tax return data, but IRS confirms such data is not available. We also support HHS's proposal to provide those with DMI additional time to provide documentation. We recognize that consumers may be stymied by the process to resolve their inconsistencies. This is due to systems issues, faulty notices, and a lack of receipt of notices. The result is that many consumers who have DMIs believe they have sent in sufficient documents to resolve their DMI only to find out after the end of the DMI reasonable opportunity period that they actually did not resolve the DMI and instead have had their APTCs reduced or terminated.

The impact of the faulty DMI resolution process has left many consumers responsible for paying the full premiums to their issuer after the end of the inconsistency period and during the appeal process, which often takes longer than ninety days. For consumers determined initially eligible for APTCs, this can create an extreme financial hardship and puts these consumers in a bind of maintaining coverage with full premiums versus losing coverage and possibly suffering financial hardship if they incur medical expenses or an individual responsibility payment if coverage lapses for more than three months.

While an appeal resolution can provide retroactive coverage, this is of little comfort to consumers experiencing financial burdens during the appeal period. The appeals process often takes longer for many consumers expect, extending the time period for which they have to pay full premiums to maintain coverage or remain uninsured and at risk of incurring significant medical costs if an emergency arises or they have an ongoing or chronic condition needing treatment.

E. Annual Eligibility Redetermination (§ 155.335)

Selecting a health insurance plan is complicated, and many people, regardless of education level, find it difficult to make a choice and often do not change their choice once it is made.[31] Studies show that people routinely pick plans that are not the most beneficial.[32] In one study, only five percent of people did better at choosing an ideal plan than they would have by choosing a plan at random.[33] That same study found that if

[30] 87 Fed. Reg. 78257.
[31] Margot Sanger-Katz, *It's Not Just You: Picking a Health Insurance Plan is Really Hard*, N.Y. TIMES (Dec. 11, 2020), https://www.nytimes.com/2020/12/11/upshot/choosing-health-insurance-is-hard.html; Saurabh Bhargava et al., *Choose to Lose: Health Plan Choices form a Menu with Dominated Options,* Q. J. ECONS. 1319, 1323 (Apr. 27, 2017), https://www.cmu.edu/dietrich/sds/docs/loewenstein/ChoseLose.pdf.
[32] *Id.*
[33] *See* Benjamin R. Handel et al., *The Social Determinants of Choice Quality: Evidence from Health Insurance in the Netherlands,* NAT'L BUREAU OF ECON. RSCH. 4 (Sept. 2020),

individuals with lower socioeconomic status (and in particular, individuals with less education), are less likely to make complex decisions.

We recognize a default process for auto-reenrolling consumers is necessary, as some consumers will not actively return to the Marketplace to make plan choices during open enrollment. We also agree that the current default re-enrollment hierarchy sometimes encourages consumers to remain in plans that are significantly more expensive than the lowest-cost plans available.

We commend HHS for continuing to improve the re-enrollment process to better serve consumers' interests. We support the new re-enrollment hierarchy for enrollees who would otherwise be automatically reenrolled in a bronze-level Qualified Health Plan (QHP) without Cost Sharing Reductions (CSRs), to instead be automatically reenrolled in a silver-level QHP (with income-based CSRs) in the same product with a lower or equivalent premium.

Researchers found that in Covered California's 2018 market, fully thirty percent of households whose coverage was automatically renewed were certain to be better off in a different plan. On average, families were charged an extra $466 a year in annual premiums by remaining with a plan that no longer served their interests.[34]

Our experience working with Navigators and other enrollment assisters confirms that affordability continues to drive consumer concerns. However, we have also observed increased consumer recognition of the importance of continuity of providers and covered services and cost-sharing structure. We appreciate HHS's challenge in devising a reenrollment methodology prioritizes affordability, while considering continuity of coverage, and providers, and also encouraging consumers to play an active role in regularly evaluating and choosing their plan.

Our experience shows that consumers rarely prioritize continuity of issuer. Consumers care about their providers, coverage of services they use, and cost-sharing policies. While some

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https://www.nber.org/system/files/working_papers/w27785/w27785.pdf; *see also* Jonathan Gruber et al., *Managing Intelligence: Skilled Experts and AI in Markets for Complex Products*, NAT'L BUREAU OF ECON. RSCH. (Apr. 2020), https://www.nber.org/system/files/working_papers/w27038/w27038.pdf (finding that an algorithm has better outcomes than professionals trained to help people select plans when the decisions are financial). Although the Handel study is based in the Netherlands, the authors explicitly connected the findings to U.S. Marketplace choices. The study found that individuals with lower education and income chose higher deductible plans, calling into question the theory that people will choose to engage in activities to lower deductibles or cost-sharing. Other studies have found that even when other influences on plan choice are controlled for and the only choices are financial, people make harmful financial choices because health insurance is difficult to understand. *See, e.g.,* Bhargava, *supra* note 31. The same study challenged the standard practice of inferring risk preferences from consumer insurance choices. *Id*.

[34] Petra W. Rasmussen & David Anderson, *When All That Glitters is Gold: Dominated Plan Choice on Covered California for the 2018 Plan Year*, MILBANK Q. (Dec. 2021), https://www.milbank.org/quarterly/articles/when-all-that-glitters-is-gold-dominated-plan-choice-on-covered-california-for-the-2018-plan-year/.

correlation may exist between continuity of issuers and providers/policies, this is not always the case. Therefore, we do not support an approach that prioritizes continuity of issuer, as the network and policies of a "similar" issuer plan may create a false sense of continuity. Instead, we believe continuity should be measured by providers, cost-sharing structure, and coverage policies, with continuity of primary care provider (PCP) being the simplest proxy for provider continuity (and recognizing that for some consumers, a primary care provider may indeed be a specialist such as women whose gynecologist serves as a PCP or individuals with disabilities who may have a specialist providing the primary source of care).

Ultimately, for consumers who do not shop at all during open enrollment, the vast majority care more about cost than carrier or provider network. Accordingly, we recommend that HHS prioritize in the default reenrollment hierarchy that when the consumer's former plan is no longer offered, auto-enrolling the consumer in the most generous plan that that is closest to the former plan.

The notice informing the consumer of the change in plan should let the consumer opt out of the change by selecting a different plan, chosen based on the current reenrollment hierarchy, or by terminating coverage altogether. However, the default assignment, in case of complete consumer inaction, should prioritize affordability, rather than continuity of carrier and product line.

F. Special Enrollment Periods (§ 155.420)

We support the proposed changes at § 155.420(a)(4)(ii)(A) and (B). These are technical changes to clarify that only one person in a tax household applying for coverage or financial assistance through the Marketplace must qualify for a special enrollment period (SEP) under paragraphs (d)(6)(i) and (ii) in order for the entire household to qualify for the SEP.

1. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

NHeLP strongly supports the proposed change at § 155.420(b), which will give Marketplaces the option to offer earlier coverage effective start dates for consumers with a future loss of minimum essential coverage (MEC). This will help individuals who lose non-Marketplace coverage mid-month avoid a gap in coverage before their Marketplace coverage is effectuated. This will certainly help individuals in states who terminate Medicaid and CHIP coverage mid-month. This proposed change will be particularly helpful in light of the large volume of transitions anticipated from Medicaid/CHIP coverage to Marketplace coverage at the end of the Medicaid continuous coverage requirement.

This proposed change will provide expedient access to Marketplace coverage and financial assistance so that consumers can get the care they need. When consumers have gaps in health insurance coverage, health care utilization declines, which can lead to poorer health

outcomes. Gaps in health care coverage result in increased non-adherence in the treatment of potentially serious medical conditions.[35] For example, treatment gaps can have deadly consequences for some, including people living with HIV/AIDS where "even short interruptions of care can threaten health and undermine prevention effects."[36] Coverage gaps exacerbate ongoing racial and ethnic disparities in treatment adherence for persons with chronic conditions.[37]

This proposed change will help consumers avoid the difficult decision between paying out of pocket for medically necessary care when they are uninsured and foregoing care that could negatively impact their health.

Given that this proposed change may result in some consumers having overlapping coverage for part of a single month, we recommend that Marketplace give the consumer the option of the earlier or later Marketplace start date. Some consumers may opt for the later start date due to complexities of overlapping coverage and ongoing medical needs.

2. Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

Under current rules, the loss of MEC triggers a sixty day special enrollment period (SEP) in which an individual can enroll in a Marketplace plan.[38] However, as HHS notes, sixty days after Medicaid termination, enrollees could still be attempting to establish Medicaid eligibility, and they could miss the opportunity to enroll in Marketplace plans with APTC.[39]

NHeLP supports extending the sixty-day SEP resulting from loss of Medicaid or CHIP to ninety days. The SEP change can help to mitigate gaps in coverage during the unwinding of the Public Health Emergency (PHE).

However, we disagree with HHS's proposal to make the ninety-day SEP optional. First, we note that federal rules already provide Marketplaces broad authority to grant SEPs under "exceptional circumstances."[40] Second, the ninety-day alignment between Marketplace rules for loss of Medicaid and CHIP, and the Medicaid/CHIP ninety-day reconsideration period, should be mandatory, not optional. Finally, we object to delaying implementation of

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[35] See, *e.g.*, Laura E. Happe et al., *A systematic literature review assessing the direction impact of managed care formulary restrictions on medication adherence, clinical outcomes, economic outcomes, and health care resources utilization*, J MANAG CARE SPEC PHARM; 207):67-84 (2014); Dr. C. Daniel Mullins et al., *Persistence, switching, and discontinuation rates among patients receiving sertraline, paroxetine, and citaliopram*, PHARMACOTHERAPY 25-660-7 (2005).
[36] Dana P. Goldman et al., *The Prospect Of A Generation Free Of HIV May Be Within Reach If The Right Policy Decisions Are Made*, 33 HEALTH AFFAIRS, 430 (2014).
[37] Zhiwen Xie et al., *Racial and ethnic disparities in medication adherence among privately insured patients in the United States*, PLOS ONE (Feb. 14, 2019), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0212117&type=printable.
[38] 45 C.F.R. § 155.420(c)(1).
[39] *See* 42 C.F.R. 42 C.F.R. § 435.916(a)(3)(iii), allowing Medicaid enrollees a ninety-day reconsideration period to correct any erroneous information and re-establish Medicaid eligibility
[40] 45 C.F.R. § 155.420(d)(9).

the extended SEP to January 2024. Now that the Consolidated Appropriations Act, 2022 has delinked the continuous coverage policy from the PHE and stated that eligibility redeterminations can begin again on April 1, 2023, millions of Medicaid and CHIP enrollees could face termination much sooner than January 2024.

3. Plan Display Error Special Enrollment Periods (§ 155.420(d))

We support HHS's proposal to provide a SEP to consumers who encounter a material error related to plan benefits, service area, cost-sharing, or premium. While it is important to protect consumers from the consequences of material errors that influence plan selection, HHS should take all necessary steps to prevent such errors from happening in the first place.

G. General Eligibility Appeals - Requirements (§ 155.505)

HHS clarifies the timeline for eligibility appeals and authority of the CMS Administrator to review Marketplace eligibility appeals decisions prior to judicial review. We recognize the ACA confers authority not only establish appeals processes, but that the HHS Secretary also "hears and makes decisions with respect to appeals."[41]

HHS should make every effort to ensure that right decision is made at the lowest level of review.

## II. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

A. FFE and SBE–FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

User fees are essential to operate the Marketplace, improve the consumer interface, provide consumer support, fund outreach, and overall ensure a smooth enrollment system for consumers. Over the years, we have identified a number of issues that HHS should address throughout HealthCare.gov. These include enhancing the consumer experience through improvements to the application and healthcare.gov as well as addressing other behind-the scenes issues.[42] We believe HHS should maintain the current user fees until it completes much needed fixes and enhancements.

[41] *See* 42 U.S.C. § 18081(f)(1)(A).
[42] For example, HHS should create a dashboard for navigators and assisters to better track their clients; establish linkages between healthcare.gov and the appeals unit so the appeals unit has ready access to documents consumers have provided and also effectuate appeals; and provide the call center ready access to any documents submitted by the consumer to resolve a DMI.

B. Standardized Plan Options (§ 156.201)

Plans that share a common benefits structure, including tiering and cost-sharing, allow consumers to make apples-to-apples comparisons of plans and benefits. NHeLP strongly supports HHS's efforts to require issuers in the FFE and SBE-FPs to offer at least one standardized plan at every product network type, metal level, and in every service area where the issuer also offers non-standardized plans.

A recent Assistant Secretary for Planning and Evaluation (ASPE) issue brief indicates that "almost three quarters of *HealthCare.gov* consumers have *more than 60 plan options* to choose from, and the average number of plans is *over 100*" (emphasis added).[43] Because health care is not a typical consumer good, the usual understanding that more is better for the consumer does not hold true in the Marketplace. On the contrary, the high number of plan options often leads to confusion among shoppers, which in turn gives way to consumer errors during plan selection. As the ASPE reports finds, a higher number of plan options runs counter to the central premise of the ACA, which relies on plan competition to increase the value of health care and requires informed consumers to "select among competing plans to realize that value."[44] Choice overload, on the other hand, often leads consumers to make selections without regard to value and discourages consumers from switching from lower-value plans to higher-value plans.

While HHS's proposal does not directly limit the number of plan options available to consumers in the Marketplace, it will nonetheless enable consumers to make apples-to-apples comparisons of plans sharing a common benefit and cost-sharing structure. The ACA generally achieved common benefit structure across plans through the requirement that Marketplace plans cover EHB, but lack of cost-sharing standardization has allowed issuers to offer an unlimited number of plans. Through the standardization proposal, consumers could compare plans without regards to cost-sharing requirements, allowing individuals to focus on other factors that are better indicators of the plan's value and that are more crucial to consumers' health, such as premiums, provider network, and quality of services.

Standardization also serves as a tool to improve affordability and address health disparities in the Marketplace. HHS's proposal will ensure that consumers always have access to at least one plan that exempts certain essential services, including emergency room services, primary care visits, and mental health and substance use disorder treatment, from deductibles. Because people of color and other underserved populations often lack access to such services that are key to prevent further health complications, exempting these

[43] U.S. Dept. of Health & Human Servs., Assistant Sec'y for Plan. and Evaluation ("ASPE"), *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 1 (2021), https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.
[44] *Id.* at 4.

services from the deductible in all standardized plans will make it easier for these communities to receive the care they need and help close gaps in access to care.[45]

The effectiveness of standardization in improving access and affordability is evident by the experience of the nine states and the District of Columbia that have already adopted standardization in their state-run Marketplaces. In particular, our experience as consumer advocates in California, the only state that requires *all* plans in the Marketplace to be standardized, solidifies our support for HHS' standardization proposal. California has required all plans to be standardized since Covered California's inception in 2014. The result of this policy has been that consumers are able to navigate the Marketplace and shop around without having to worry about price variation within particular tiers and service areas. In turn, this ease of access has led to robust coverage across all counties in California alongside significant, albeit incomplete, improvements in the quality of care provided due to competition being based on plans' overall value instead of cost.

Despite our strong support for the standardization proposal, we are concerned that some of the cost-sharing in standardized plans remains too high and unaffordable for beneficiaries with high needs. To improve affordability of drugs used to treat people with disabilities and those with chronic conditions, we recommend that HHS exempt them from deductible requirements across silver plans, which represent the bulk of enrollment in the Marketplace. In addition, copays for specialty drugs remain too high and unaffordable for most individuals. As such, we urge HHS to evaluate the possibility of lowering copayments for "specialty" drugs without the need to increase cost-sharing for other services pursuant to the AV calculator.

We further urge HHS to prohibit coinsurance, which is inherently discriminatory and unduly shifts the costs of care to persons with high health needs. Coinsurance also increases confusion among consumers because even more experienced consumers may fail to understand that a lower coinsurance percentage may nonetheless represent a higher out-of-pocket amount than copayments. Coinsurance is particularly invidious for prescription drugs, for which actual prices vary considerably. Consumers are ill-equipped to consider these price variations and plans do not provide information on the dollar amount of coinsurance a consumer can expect to be charged.

[45] For a discussion about how issuers use benefit manipulation and "adverse tiering" to discriminate against individuals with high-cost needs and how standardization helps fix this problem, *see* Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFF. (2016), https://www.healthaffairs.org/do/10.1377/forefront.20160106.052546.

C. Non-Standardized Plan Option Limits (§ 156.202)

In recent years, there has been a sharp increase in the number of plans available to consumers. In 2019, in the FFE and SBE-FPs, an average of 27.1 plans were available per enrollee.[46] This number climbed to 109.2 plans per enrollee in 2022.[47]

A recent RAND Corporation study shows that when consumers are given too many plan choices, there is the greater potential to make poor enrollment decisions. Multiple factors result in less than optimal plan choice decision making, including but not limited to the challenge of processing complex health plan information, inadequate decision support tools, and low health literacy and numeracy.[48] Consumers may incorrectly calculate costs, or focus on premiums without even considering total out-of-pocket costs. When there are too many options, consumers may also be susceptible to how choices are presented on the website. For example, someone might select a plan merely because it is presented first on the website. Of most concern, consumers may experience decision fatigue and not enroll in health insurance at all.

In an effort to simplify the plan choice decision-making process, NHeLP supports HHS's proposal to establish a numeric limit on the availability of non-standardized plans. However, we urge HHS to also require a meaningful difference in the plans offered, by reinstating the standard previously codified at 45 C.F.R. § 156.298. This would limit the volume of nearly similar plans so that consumers can readily compare plan, and also ensure that consumers have real choices when selecting a plan.

In addition to limiting plan selection, the evidence shows that outreach efforts help optimize plan selection and help consumers avoid choice errors. A Covered California analysis found that nearly 20,000 Covered California consumers selected more expensive gold and platinum plans in 2019 despite being eligible for a less expensive enhanced silver plan with richer benefits.[49] Covered California sent additional emails and letters to these consumers describing the financial savings if they switched to the silver product, and as a result, roughly twenty percent of these individuals switched to a silver plan with a lower premium and cost-sharing savings.[50] This analysis clarifies that consumers make suboptimal plan selections simply because of the sheer number of plans to choose from, and the complexity of information on Marketplace platforms. HHS should require Marketplaces to implement a

[46] U.S. Dept. of Health & Human Srvs., Notice of Benefit and Payment Parameters for 2023, 87 Fed. Reg. 584, 690 (Jan. 5, 2022) https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf.
[47] *Id*.
[48] Erin Audrey Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace,* RAND Corp. (2016), https://www.rand.org/pubs/research_reports/RR1567.html.
[49] Andrew Feher & Isaac Menashe, *Using Email and Letters To Reduce Choice Errors Among ACA Marketplace Enrollees*, Health Affs. 812, 814 (May 2021), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02099
[50] *Id.* at 815.

multi-pronged approach to helping consumers navigate the platforms to make sound plan selections.

D. Network Adequacy (§ 156.230)

NHeLP commends HHS's decision to amend §§ 156.230 and 156.235 to clarify that only plans that use networks may participate in the Marketplace. NHeLP has long raised concerns about people's ability to access care and control their health care costs in non-network plan models. The decision to allow only network model plans to participate, based on HHS's experience that few non-network plans have participated in the Marketplace in fact, and that it is difficult for HHS to ensure that enrollees in those plans have adequate access to care, is extremely sensible. We are not aware of any regulatory standards that evaluate whether a non-network plan offers a sufficient selection of providers without excessive burden on its members.[51]

NHeLP agrees with HHS's assumption that most people prefer plans, including Stand Alone Dental Plans (SADPs), that use a network, since it is easier for them to understand which providers are covered under their plan. Furthermore, over the last several years, the market has become more and more dominated by network plans.[52] While non-network plans are more common for SADPs than for health plans, they are still increasingly rare.[53] In any event, given the inherent difficult in ensuring that non-network plans provide enrollees with adequate access to care without undue burden, we support the proposed change.

In addition, NHeLP urges HHS to take additional action to ensure that QHPs are complying with existing network adequacy standards. We appreciate the work HHS has done to ensure that QHPs are subject to robust network adequacy standards so that they are able to make covered services available to their enrollees. Despite these standards, reports

[51] We note that California's Department of Insurance has issued adequacy and access standards that apply across licensed health care products, including both network plans (such as PPOs) and traditional indemnity plans. *See* Cal. Dep't Ins., Provider Network Adequacy, http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm (last visited Jan. 10, 2023). While these standards to account for the selection of providers, they do not measure the burden on members, and thus we cannot recommend them to HHS. We also note, however, that traditional indemnity plans make up an increasingly small portion of the insurance market in California, as in other jurisdictions. *See, e.g.,* Gary Claxton et al., Kaiser Family Found. & Health Res. & Ed. Trust, *Employer Health Benefits: 2016 Survey* at 76 (2017), https://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey (less than 1% of people enrolled in employer-sponsored insurance nationally were enrolled in a non-network plan in 2016).

[52] *See* Claxton et al., *supra* note 54 at 71-76; *see also* Christen Linke Young & Kathleen Hannick, USC-BROOKINGS SCHAEFFER, *Fixed Indemnity Health Coverage is a Problematic Form of "Junk Insurance"* (Aug. 4, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance.

[53] *See, e.g.* Avery Smith, DentalInsurance.com, *Indemnity Dental Insurance* (Dec. 14, 2022) (estimating that indemnity plans comprised 6% of the dental insurance market in 2022), https://www.dentalinsurance.com/resources/dental-plans/indemnity-dental-insurance.

abound of network adequacy issues in QHPs, particularly regarding access to behavioral health services.[54] Thus, vigorous enforcement is needed to ensure that QHPs' networks are sufficient to provide access to covered services.

E. Essential Community Providers (§ 156.235)

Essential Community Providers (ECPs) provide care to predominately low-income and medically underserved populations, and are important to improving health outcomes and advancing health equity.[55] BIPOC people face significant barriers in access to and utilization of care.[56] Nonelderly BIPOC individuals face increased barriers to accessing care compared to whites and have lower utilization of care. For example, preterm birth rate for Black people is fifty-one percent higher than the rate among people of other races, and Black people also experience higher rates of certain chronic conditions such as diabetes, hypertension, and sexually transmitted infections, which can result in poor birth outcomes if unidentified or unmanaged before pregnancy.[57] Increasing ECP participation in QHPs is an important step toward addressing these disparities.

1. Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers

HHS proposes to add Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers as stand-alone ECP categories beginning in FY 2024. We support this proposal.

Millions of people in the United States have a behavioral health condition, but do not receive the care they need. More than one in five adults (57.8 million people) have a mental health condition, while an estimated 46.3 million adolescents and adults live with a SUD.[58] Despite the prevalence of these conditions, people with behavioral health conditions struggle to find care. Over half of people with a mental health condition did not receive any care.[59] Only 6.3% of individuals ages twelve or older who needed SUD treatment in the past year received it.[60]

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[54] *See, e.g.,* Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39 HEALTH AFF. 975 (2020).
[55] Cristina Jade Peña *et. al.,* Kaiser Family Found., *Federal and State Standards for "Essential Community Providers" under the ACA and Implications for Women's Health* (2015), http://files.kff.org/attachment/issue-brief-federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health.
[56] Samantha Artiga & Kendal Orgera, Kaiser Family Found., *Key Facts on Health and Health Care by Race and Ethnicity* (2019), https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-coverage-access-to-and-use-of-care.
[57] March of Dimes, *2021 March of Dimes Report Card* 2 (2021), https://www.marchofdimes.org/materials/March_of_Dimes_US_2021_Report_Card_11152021.pdf.
[58] Substance Abuse & Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* 39, 46 (2022), https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf
[59] *Id.* at 58.
[60] *Id*. at 51.

The unmet need for mental health services is particularly serious among groups that have historically experienced discrimination. For example, African Americans, American Indians, and Alaska Natives access mental health services at substantially lower rates than white Americans.[61] The COVID-19 pandemic has had significant impacts on behavioral health, with sharp increases in the prevalence of conditions in specific populations, such as young adults, people of color, essential workers, and unpaid caregivers, experiencing a disproportionate impact.[62]

Studies repeatedly demonstrate that people with behavioral health conditions who have insurance encounter difficulty locating, receiving, and affording care.[63] In particular, people with behavioral health conditions report difficulties finding in-network providers that are taking new patients.[64] As a result, some people delay or forego care entirely, while others seek out-of-network care, at far higher costs.[65] Given all of this, we support HHS's proposal to create standalone categories for SUD Treatment Centers and Mental Health Facilities as stand-alone ECP categories for improving access to care among low-income and medically underserved populations.

We also support the proposal to crosswalk the Community Mental Health Center (CMHC) provider type into the newly created Mental Health Facilities category. However, as currently written, HHS defines Mental Health Facilities as CMHCs and "other mental health providers."[66] While we support including other mental health providers in the definition of a "Mental Health Facility," it would be helpful to further define what other types of providers beyond CMHCs might fall in the ECP Mental Health Facilities Category. HHS may want to limit providers to those that are subject to some additional conditions of participation or other indicia of quality. This could help ensure that plans contract with facilities that provide

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[61] Azza Altiraifi & Nicole Rapfogel, Ctr. for Am. Progress, *Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis* (Sept 10, 2020), https://www.americanprogress.org/article/mental-health-care-severely-inequitable-came-coronavirus-crisis/.

[62] Ctrs. for Disease Control & Prevention, *Morbidity and Mortality Weekly Report: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020* (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf.

[63] See, *e.g.*, Nat'll All. on Mental Illness, *The Doctor is Out: Continuing Disparities in Mental Health Care* (2017), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut; Nat'l All. on Mental Illness, *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity* (2016), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf;

[64] Steve Melek et al., Milliman, *Milliman Research Report: Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (2019), https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

[65] *Id. See also*, Nicole M. Benson & Zirui Song, *Prices and Cost-Sharing In-Network vs. Out-of-Network for Behavioral Health, 2007-2017* 39 HEALTH AFF. 1210-1218 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8128060/#R1.

[66] 87 Fed. Reg. 78290.

some basic level of services, that adhere to patient rights protections, and that provide services in the least restrictive setting appropriate.

Similarly, we urge HHS to further define what types of treatment facilities can fall into the SUD Treatment Center category. Given how widespread ineffective and low-quality SUD providers are, we especially note that it is important that HHS not allow QHPs to fulfil their obligations in this area by contracting with low-quality providers.[67] At a minimum, this means that SUD providers should be able to provide onsite, or refer patients to Medication Assisted Treatment (MAT). In addition, QHPs should be responsible for periodically reporting access and quality information that enables HHS and states to identify which SUD services are being utilized and for which services gaps remain, as well as information about demographics and access data to address potential health disparities in access to SUD care.

2. Family Planning Providers and Federally Qualified Health Centers

HHS proposes that for PY (Plan Year) 2024 and beyond, QHPs must contract with at least thirty-five percent of available Federally Qualified Health Centers (FQHCs) and at least thirty-five percent of available Family Planning Providers that qualify as ECPs in the plan's service area. These requirements would be in addition to the existing provider participation requirement, which states that QHPs must contract with thirty five percent of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the thirty-five percent threshold.

We support this proposal, which will help ensure that QHP enrollees, especially those who have low-incomes and those who are BIPOC, have full access to these important benefits. However, we remain concerned that HHS continues to relegate the ECP threshold setting to sub-regulatory action. Given the ongoing attacks on health care access, especially reproductive health, we urge HHS to codify the ECP thresholds in regulation.

Accordingly, we urge HHS to amend the regulatory text to require QHPs to include thirty-five percent of available ECPs in their networks. We continue to support HHS's decision to treat multiple providers at a single location as one ECP, and to require QHPs with tiered networks to meet the ECP threshold in the lowest cost-sharing tier.

**RECOMMENDATION:** We suggest that HHS amend §§ 156.235(a)(2)(i) and (b)(2)(i) as follows:

> (a)(2)(i) The QHP issuer's provider network includes as participating providers at least ~~a minimum~~ ***35*** percent~~age, as specified by HHS,~~ of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph

[67] Brian Mann, *As Addiction Deaths Surge, Profit-Driven Rehab Industry Faces 'Severe Ethical Crisis'*, NPR (Feb. 15, 2021), https://www.npr.org/2021/02/15/963700736/as-addiction-deaths-surge-profit-driven-rehab-industry-faces-severe-ethical-cris.

(ii)(B) of this section, and at least ~~a minimum~~ ***35*** percent~~age~~ of available ECPs in each plan's service area within ***the FQHC and Family Planning Provider*** ~~certain individual~~ ECP categories~~, as specified by HHS~~.

…

(b)(2)(i) (i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies ~~a minimum~~ ***35*** percent~~age, specified by HHS,~~ of available essential community providers in the plan's service area ***collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this provision, and satisfies thirty-five (35) percent of available ECPs in each plan's service area within the FQHC and Family Planning Provider ECP categories***.

3. Expanding the "Other ECP Providers" category and clarifying contracting requirements (§ 156.235(a)(2)(ii) & (b)(2)(ii))

We suggest that HHS add the category of "Freestanding Birth Centers" to the Other ECP category, as this is a crucial service for pregnant enrollees. The Strong Start for Mothers and Newborn Initiative, which concluded in 2018, found "significantly improved outcomes" for participants who gave birth at freestanding birth centers (as opposed to receiving care at maternity care homes or group prenatal care).[68]

Moreover, NHeLP understands that there may be rare cases where QHP issuers are not able to reach an agreement with any ECPs in a particular category in a particular region. To address these cases, we support HHS' explicit incorporation of a good faith standard to ensure that QHP issuers have made real efforts to establish contracts with ECPs. We support the language HHS has included in previous guidance specifying that to be considered a good faith offer, a contract must offer rates and contract provisions that a "willing, similarly situated non-ECP provider would accept or has accepted."[69] We urge HHS to specify that good faith contract terms must include all of the services the plan covers and the ECP provides, and include reimbursement at generally applicable payment rates. We are concerned that without additional specificity, issuers will continue to use a low-reimbursing contract as verification, forcing ECPs into lower reimbursement rate contracts. Without a strong requirement that QHPs make real efforts to establish legal agreements, the overall goal of the guidance will be eroded and QHP issuers will be able to evade the ECP standard by offering ECPs contracts but not following through on them.

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[68] Adam Boehler & Mary C. Mayhew, Ctr. Medicaid & Medicare Servs., *Joint Informational Bulletin: Strong Start for Mothers and Newborns initiative (Strong Start)* (Nov. 9, 2018), https://www.medicaid.gov/federal-policy-guidance/downloads/cib110918.pdf; *see also* Embry Howell et al., *Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center*, 4 Medicare & Medicaid Res. Rev. E1 (2014), https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a06.pdf.

[69] *See, e.g.,* Ctrs. Medicare & Medicaid Servs., *Frequently Asked Questions on Essential Community Providers* 4 (2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-on-ECPs-6-12-14.pdf.

Moreover, HHS should encourage Marketplaces to look closely at any QHP issuer that lacks contracts with ECPs, as that fact alone raises an inference that the issuer's offers have not been made in good faith.

**RECOMMENDATION:** We suggest that HHS amend § 156.235(a)(2)(ii) and (b)(2)(ii) as follows:

> (a)(2)(ii) The issuer of the plan ***makes good faith*** offers ***of*** contracts***, considering generally applicable payment rates and contract provisions that a willing, similarly situated non-ECP provider with median rates would accept or has accepted,*** to—
>
> . . .
>
> (B) At least one ECP in each of the eight (8) ECP categories in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type. The ECP categories are: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, and Other ECP Providers. The Other ECP Providers category includes the following types of providers: Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, ~~and~~ Rural Emergency Hospitals***, Freestanding Birth Centers, and other entities that serve predominantly low-income, medically underserved individuals***.
>
> . . .
>
> (b)(2)(ii) The issuer's integrated delivery system provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard, or otherwise ***makes good faith*** offers ***of*** a contract***, considering generally applicable payment rates and contract provisions that a willing, similarly situated non-ECP provider with median rates would accept or has accepted,*** to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area that can provide those services to low-income, medically underserved individuals.

4. ECP write-in option (§ 156.235(a)(3) & (b)(3))

In addition, HHS states that it will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the HHS list of available ECPs. We urge HHS to eliminate this option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard but still have a network that is sufficient to meet the needs of low-income and underserved enrollees. This

provision has the potential to become the exception that swallows the rule. Without an adequate number of ECPs in an issuer's network, people who rely on ECPs for their care will have less access to the care they need. Given the importance of including ECPs in QHP networks, HHS should not provide issuers with leeway to avoid meeting its ECP standards. We recommend that HHS eliminate §§ 156.235(a)(3) and 156.235(b)(3).

5. Other considerations regarding ECPs

We again acknowledge that the tension between provider shortages and the ease of telehealth is very real, particularly in rural communities and for specialized health services. The use of telehealth should not undermine ECP and other access to care protections.

Rather, HHS should encourage QHPs to consider telehealth as another tool in which to improve access while emphasizing that telehealth cannot replace in person health care. We acknowledge that many ECPs including FQHCs and family planning providers have offered critical services during the pandemic using telehealth, but emphasize that ultimately, the modality of service (whether it is telehealth or in-person) must be dictated by the patient's preference and best interests.

We also note here that HHS should ensure that QHP issuers rigorously monitor and enforce ECP participation in their networks. HHS should require QHPs to comply with monitoring and enforcement policies that ensure adequate oversight of QHP networks' compliance with ECP standards throughout the coverage year. We recommend that HHS require issuers to report any material changes to their ECP contracts within thirty days, and ensure that at no time their network falls below the ECP minimum standards. We urge HHS to require Marketplaces to consider access to ECPs in any monitoring and enforcement that it undertakes related to network adequacy as a whole, in addition to monitoring for compliance with ECP standards separately.

F. Termination of Coverage or Enrollment for Qualified Individuals (§ 156.270)

We agree that providing timelines for delinquency notices is important. Without timeliness standards, an individual may not receive timely notice and individuals should not be penalized and potentially lose their coverage because they did not understand what was owed, the deadlines for repayment, or the timeframe of the grace period. If an individual does not receive timely notice of a triggering event—in this case a delinquency—and was reasonably unaware of the delinquency, an issuer should ascribe the date the individual knew or should have known of the triggering event.

Timeliness standards will help avoid situations where consumers do not know of a delinquency until it becomes harder to rectify. Particularly for low-income consumers and those on fixed incomes, accumulating a delinquency over a few months could lead them unable to pay what is needed while a timely notice within a short period of nonpayment may lead them better able to pay what is due.

As we have noted in our comments on previous years' NBPP, terminations of any kind result in a change of circumstances for an enrollee and they must understand the reason for the termination as well as their legal rights to challenge it.[70] As HHS noted in the 2022 NBPP Final Rule, complaints about terminations are one of the largest sources of casework.[71] Ensuring timely notification about delinquencies and ensuring individuals have sufficient time to address a delinquency, may help address the number of cases needing assistance after a delinquency leads to a termination.

Further, we strongly recommend that HHS require delinquency notices include taglines (including a large print tagline). Individuals with LEP and/or sight issues need to understand the importance of a delinquency notice and how to respond. We believe the regulation should explicitly require taglines because otherwise these individuals will not receive effective notice and could lose their coverage.

We recommend that an insurer send an initial delinquency notice within two calendar weeks of the initial delinquency.

**Conclusion**

We have included citations and direct links to research and other materials. We request that the full text of material cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these citations part of the record as we have requested, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

Thank you for the opportunity to comment on these important issues. Please feel free to contact me at (202) 289-7661 or turner@healthlaw.org if you have questions.

Yours truly,

Wayne Turner
Senior Attorney

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[70] See, *e.g.*, Nat. Health Law Program, *Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016* (Dec. 21, 2014), https://healthlaw.org/resource/nhelp-comments-notice-of-benefit-and-payment-parameters/.
[71] U.S. Dept. of Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2022 Final Rule*, 86 Fed. Reg. 24239 (May 5, 2021), https://www.govinfo.gov/content/pkg/FR-2021-05-05/pdf/2021-09102.pdf.