



January 8, 2024

The Honorable Janet Yellen
 Secretary
 U.S. Department of the Treasury
 1500 Pennsylvania Avenue NW
 Washington, DC 20220

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

The Honorable Chiquita Brooks-LaSure
 Administrator Centers for Medicare and Medicaid Services
 U.S. Department of Health and Human Services
 200 Independence Avenue SW
 Washington, DC 20201

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program (CMS-9895-P)

Dear Secretary Yellen, Secretary Becerra, and Administrator Brooks-LaSure:

Thank you for the opportunity to submit comments on the Notice of Benefit and Payment Parameters for 2025 Proposed Rule, issued by the Department of Treasury, the Department of Health and Human Services (“HHS” or the “Department”), and the Centers for Medicare and Medicaid Services (CMS).

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

In March of 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

More than 19 million people have signed up for a marketplace plan as of December 15 for Healthcare.gov states and December 9 for state-based marketplaces.² We appreciate the administration's ongoing commitment to improving the accessibility, affordability, and adequacy of care for all patients and are confident that many of the policies included in the proposed rule will continue to advance these shared goals. We offer the following comments and recommendations addressing specific provisions of the proposed rule:

Standards for Establishing and Operating a State-Based Marketplace

A core goal of the ACA's marketplaces was to reduce the burden of shopping for a health plan, by giving consumers a single place to view their coverage options and the tools to understand and compare them. In part because of the Department's efforts to improve the marketplace shopping experience and support consumers in the states that use HealthCare.gov, millions of individuals now can, and do, rely on the federal marketplace to access affordable, comprehensive health insurance.

States whose residents have until now benefited from HealthCare.gov still have an opportunity under the ACA to establish and operate their own marketplace. The existing state-based marketplaces (SBMs) have played a vital role in improving access to quality coverage and we believe states newly seeking to run their own enrollment platforms can and must do the same.

Any state that wishes to assume responsibility for their own marketplace must ensure that the transition from HealthCare.gov to an SBM will further the goals of the ACA and will not make consumers worse off. The ACA's marketplace establishment provisions do not license state policy variation for its own sake. Rather, marketplaces and marketplace policy must serve the best interests of patients and consumers. Transitions that result in residents losing access to patient-friendly programs and protections that they currently benefit from through HealthCare.gov undermine the purpose of the statute. To avoid these harms, we have urged HHS to extend minimum federal standards to all marketplaces and require

¹ Partnership to Protect Coverage, Consensus Healthcare Reform Principles, Available at: <https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles>.

² US Department of Health and Human Services, Healthcare.gov Enrollment Exceeds 15 Million, Surpassing Previous Years' Milestones. December 20, 2023. Available at: <https://www.hhs.gov/about/news/2023/12/20/healthcaregov-enrollment-exceeds-15-million-surpassing-previous-years-milestones.html>.

transitioning states to be transparent about their plans and to solicit public comment during the transition process.³

We thank the Department for its attention to all of these issues in the proposed rule. We support in full the proposals to:

- Clarify that every marketplace must operate a centralized eligibility and enrollment platform on the marketplace's website;
- Extend standards applicable to web-brokers and Direct Enrollment (DE) entities in states that use HealthCare.gov to such entities in all states, so that marketplace consumers will benefit from these baseline federal protections, regardless of where they live;
- Require all marketplace call centers to provide consumer access to a live call center representative during the marketplace's published hours of operation and clarify the various tasks these representatives must be able to perform to assist consumers with enrollment;
- Require all marketplaces to adopt an open enrollment period that begins November 1 and ends no earlier than January 15 of the applicable benefit year (but that can extend past January 15 at the marketplace's discretion).⁴

With respect to marketplace call centers: the proposed rule notes that HHS monitors call center operations through annual collections of performance data that marketplaces are required to provide under applicable regulations. We believe such data — which includes data describing call center volume, wait times, calls abandoned, and average call center handle time — is of significant public interest and request the Department to make it public in a timely manner. In addition, we also encourage the Department to establish minimum standards for call center wait times. Such standards should include protections for consumers who require assistance in a language other than English.

We also support the proposals to ensure states seeking to transition to an SBM are fully prepared to do so, and to facilitate public engagement in the marketplace transition process. We agree that, as part of an orderly transition from the federal marketplace to a full SBM (using its own enrollment website), a new SBM should be required to remain on the federal enrollment platform for at least one year before launching its own website. We understand this has been the typical practice for marketplace transitions already and believe it should be codified as a best practice. We also support the proposal to codify a transitioning state's responsibility to provide evidence supporting its implementation choices and documentation of its progress. We urge the Department to require a state to remain on HealthCare.gov unless its transition plan and supporting evidence is sufficiently robust to allow the Department to conclude the state's residents will not be harmed by the move.

Marketplace transitions have significant implications for patients, consumers and other stakeholders, yet transitioning states have not been obligated to solicit public input on their transition plans or even make the public aware of such plans. This lack of transparency and public engagement heightens the risk that a state could proceed with a transition that jeopardizes its residents' access to comprehensive coverage. We therefore wholeheartedly support the Department's proposal to require transitioning states to publish — in a timely manner — their transition Blueprints and to engage the public during the

³ Partnership to Protect Coverage, Letter to Secretary Becerra re: Patient Priorities for the Notice of Benefit and Payment Parameters, July 27, 2023. Available at: <https://www.protectcoverage.org/siteFiles/45068/07%2027%202023%20PPC-2025-Policy-Priorities-for-NBPP.pdf>.

⁴ Our support extends to all proposed revisions of 45 C.F.R. §§ 155.205, 155.220, 155.221, 155.410, and 155.420.

transition process. We also support the Department's pledge to publish these Blueprints on a federal website, and we suggest that federal publication should occur promptly, within 30 days of receipt. While the proposed rule specifies that states must provide an opportunity for interested parties to provide input, we request that the Department clarify that, for public engagement to be adequate, a state must (among other things) provide a formal notice and comment period.

Requirements for Direct Enrollment Entity Websites

While DE entities may provide value to consumers by facilitating enrollment in marketplace coverage with financial assistance, we have long expressed concern that the non-marketplace websites used by these entities pose a risk of consumer confusion and must be monitored closely for compliance with applicable federal standards. In the proposed rule, the Department describes an existing practice in which it will make changes to HealthCare.gov's display, then communicate them to a subset of DE entities, to ensure that these entities modify their enrollment websites to reflect the federal changes made to HealthCare.gov. The Department proposes to codify this practice in regulation and establish the expectation that such changes be implemented within a specific time period set by HHS. As part of its efforts, described above, to establish more explicit federal minimum standards for all marketplaces, the Department also proposes that this requirement will also apply in SBMs that operate a DE program.

We generally support these proposals. We believe a regulatory requirement that obligates DE entities to ensure their enrollment platforms incorporate, in a timely manner, the consumer experience enhancements adopted by HealthCare.gov will make it more likely that the consumers who rely on these entities will have access to the tools and information they need to select a plan that is in their best interest. We also firmly believe this obligation should apply to all marketplaces that use DE entities.

The Department observes that some DE entities may have system constraints that would prevent them from precisely implementing HealthCare.gov updates on their own websites, or otherwise may prefer to implement such changes differently. To address these situations, HHS proposes to allow DE entities to request to deviate from the HealthCare.gov changes. HHS says deviation requests would need to be approved before being implemented and the submission of such a request would not delay the deadline by which DE entities would be required to update their websites. While we recognize that there may be very limited circumstances where technical issues make it difficult for a DE entity to implement the federal changes timely, we are concerned that the proposed deviation request process could be abused to circumvent federal policy. We urge the Department to clarify that deviations may be granted only upon a showing of special need, that any approved deviation is subject to regular reassessment, and that DE entities must submit whatever additional materials the Department may require to ensure the deviation remains justified on an ongoing basis.

Network Adequacy: Standards and Oversight

Federal law requires all marketplace health plans to maintain an adequate network of providers and an accurate and up-to-date online provider directory. These protections are designed to ensure that marketplace enrollees have timely, meaningful access to the care and services they need, as well as accurate information sufficient to enable them to understand plans' networks and identify the plans and providers most likely to meet their needs. They are vital to the patients and consumers we represent.

We thank the Department for adopting a rigorous, quantitative approach to evaluating network adequacy. We believe consumers are well-served by requiring marketplace plans to meet concrete measures of network sufficiency, including time and distance rules and standards specifying the

maximum number of days enrollees may be required to wait for a provider appointment. We are pleased that all of these standards will be in use for plan year 2025.

We also appreciate that the Department requires plans to actually demonstrate compliance with these consumer-protective standards and do so on a regular and ongoing basis. We strongly support the Department's proposal, reflected in this year's letter to issuers, to require insurers to contract with an independent third-party to administer secret shopper surveys to determine compliance with federal appointment wait time standards. We also support the proposal to require insurers to report the results of these surveys to HHS — which we believe should also be made public — and to provide full documentation of the surveys themselves to the Department on request. These are important advances on behalf of patients and consumers that should result in more timely access to care and we applaud the Department for taking these steps.

To ensure networks are well-serving all enrollees, we encourage the Department to scrutinize networks for their ability to provide culturally- and linguistically-competent care as well as physically and programmatically accessible care. This should include, among other things, a rigorous assessment of whether a network includes sufficient providers with appropriate language proficiencies, and/or provides sufficient access to appropriate language services, including ASL, to ensure individuals with limited English proficiency can obtain timely care in their preferred language, and a rigorous assessment of accessibility of provider offices and medical diagnostic equipment. It also means networks must be required to ensure access to culturally appropriate care that reflects the diversity of enrollees' backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, people with disabilities, and LGBTQI+ individuals.

Additionally, HHS should continue to strengthen standards for and oversight of marketplace plan provider directories. To enable consumers to identify the plans and providers likely to meet their needs, marketplace plans must be required to indicate in their provider directories the languages, other than English, which are spoken by a provider and/or their staff as well as the accessibility of the office. Plans' directories should also clearly specify the telehealth capabilities of participating providers. More should be done, proactively, to ensure directory information is reliable — a notorious, longstanding problem, as the Department well knows. Without accurate and up-to-date information regarding participating providers, it is impossible for consumers to make informed plan selections, no matter the help they receive from enrollment assisters or shopping support tools.

Network Adequacy: Minimum Federal Standards for all Marketplaces

We previously have expressed concern about the significant variation in the standards used by, and capacity of, states to ensure that marketplace enrollees have timely access to in-network providers offering the care they need. Though marketplace plans are required by federal law to have adequate provider networks, this basic consumer protection has long been implemented differently in different states. In states with permissive standards or limited enforcement capacity, we believe consumers have been made worse off, in contravention of the federal statute.

We thank the Department for its attention to these concerns and strongly support the proposal to require all marketplace plans, in all states, to meet minimum quantitative standards of network sufficiency, before they are certified for sale. We believe that these activities — (1) applying objective, numerical tests of network sufficiency; and (2) rigorously assessing whether plans meet these standards before they can be sold — are prerequisites for ensuring that plans sold through the marketplaces are

providing consumers timely access to care, and it should be incumbent on all marketplaces to perform them.

As we have observed in the past, the decision to establish these federal baseline standards need not deprive states of the authority to customize their approach to network adequacy regulation. We support the Department’s proposal to treat federal network adequacy standards as a regulatory floor. This approach is consistent with how most ACA consumer protections have been implemented and allows states flexibility to regulate in ways that meet or exceed the federal minimum. If a state-run marketplace seeks to apply quantitative network adequacy standards that are “at least as stringent as” the federal minimum — as that phrase is defined in the proposal — we agree it should be permitted to do so.

Similarly, we recognize that there may be instances where a state-run marketplace conducts rigorous pre-certification reviews of plan networks using a quantitative framework that is different from the federal one but does the essential job of ensuring network adequacy just as well. In such instances, as described in the proposed rule, an exceptions process that permits the marketplace to maintain its approach is appropriate. However, we urge the Department to ensure that an exceptions process is itself rigorously applied and includes the proposed threshold requirement that the state use quantitative analyses, prior to plan certification. We urge the Department to finalize its proposal to require evidence-based data demonstrating that state standards provide enrollees with a level of access to providers that is at least as great as that which is provided under the minimum federal standards. We also suggest that the Department regularly reassess all exemptions it has granted. A reassessment should occur on a standard time interval and promptly following any change in state law or regulation that affects the standards or oversight approach used by the state to assess marketplace plan networks.

Finally, the Department decided not to require all marketplaces to adopt appointment wait time standards at this juncture. However, because we believe such measures address a critical element of network adequacy not otherwise captured by time and distance standards, we request that they be incorporated into the minimum federal framework for all marketplaces in the very near future.

Standardized Plan Options: Minimum Requirements for State-Based Marketplaces and Plan Design Considerations

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

In addition, we strongly support extending this requirement to ensure that all individual market consumers have access to standardized plan options, no matter the marketplace they use. At present, most state-run marketplaces already require participating insurers to offer standardized plans. We believe the value of plan standardization for patients and consumers is sufficiently great that establishing and maintaining a standardized plan program should be a minimum expectation of all

marketplaces. We do not suggest that SBMs must adopt the exact same approach to plan standardization as HHS. But all SBMs should be required to ensure that plans with standardized cost-sharing parameters are available.

We note that extending this requirement to all SBMs is particularly important because it would ensure that consumers in a state that transitions from HealthCare.gov to a state-run enrollment platform do not lose access to standardized plans as a result of the transition. Indeed, this has just happened: Virginia consumers were able to enroll in standardized plans, via HealthCare.gov, in 2023. They are not able to do so in 2024 because the state has transitioned to an SBM and does not presently require plan standardization. While we generally support that state's efforts to establish its own marketplace, we believe Virginians would be better served were there to be a consistent requirement, across all marketplaces, to ensure plan standardization.

With respect to the design of the standardized plans themselves, we understand and appreciate the Department's desire to maintain continuity in the 2025 plan year. We do encourage HHS to continue to examine ways in which standardized plans may be used as a tool for reducing health disparities and advancing health equity. As you know, several states with standardized plan programs have already adopted plan designs that are intended, in part, to address racial disparities in the prevalence and outcomes for diabetes and other chronic conditions, and more may follow.⁵ We suggest the Department consider these efforts, and closely examine other similar opportunities, when determining plan parameters in future years.

Finally, we encourage HHS to continue to look for ways to use standardized plans to reduce barriers to care posed by excessive cost-sharing. For example, HHS should consider whether categories of services that are not subject to the deductible could be expanded, such as by including laboratory and diagnostic imaging services, and continue to prioritize copayments over coinsurance. We recognize that actuarial value rules and other considerations limit the magnitude of changes that can be made to plans' cost-sharing parameters. Nevertheless, state experiences with standardized plans suggest that additional refinements to enhance affordability can be made within existing constraints.

Standardized Plan Options: Limits on Non-Standard Plans

Current regulations establish limits on the number of non-standard plans that insurers can offer in 2024 and modestly tighten these limits starting in 2025. We strongly support these rules. As you know, the number of plans available to consumers through the marketplace has increased dramatically over time, to the point where the sheer number of plan options inhibits consumer decision-making. This environment favors the sophisticated insurers whose business it is to design health plans, at the expense of patients and consumers who must expend limited time and resources to decipher among them. Research consistently shows that consumers confronted with too many health plan choices are more likely to make poor enrollment decisions or experience choice paralysis and forgo enrollment altogether.

The limits currently established in regulation are consistent with how states have implemented standardized plan programs and there is no indication whatsoever that these limits have reduced

⁵ Monahan C, Clark J. Using Health Insurance Reform to Reduce Disparities in Diabetes Care. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2022/using-health-insurance-reform-reduce-disparities-diabetes-care>. Published August 18, 2022.

competition, insurer participation, or plan innovation.⁶ Limits on non-standardized plans do not foreclose the ability of insurers to develop innovative plan designs; rather, they ensure that consumers will be better positioned to determine whether such innovations offer unique value worth paying for.

Even under the current regulatory limits, the average consumer will be expected to sift through literally dozens of non-standardized plan options, in addition to the standardized offerings. Given this, we urge the Department not to finalize an exceptions process that would allow insurers even greater leeway to proliferate non-standard plans. While we greatly appreciate the Department's commitment to ensuring marketplace coverage works for enrollees, including people with chronic and high-cost conditions, we believe it would be counterproductive for these patients and all consumers for HHS to weaken newly established (and not yet even fully implemented) protections.

Current regulations allow numerous non-standardized plan offerings in a range of permutations. This flexibility can readily be used to design plans of the sort described in the proposed rule, without any need for a special exceptions process. We request that the Department maintain its current limits on non-standard plans without additional exceptions.

Additional State-Required Benefits

Current rules require states to defray the cost of state benefit mandates applicable to marketplace plans if, among other things, the mandate was enacted on or after December 31, 2011. Such mandated benefits are not considered to be an essential health benefit (EHB) but rather are treated as being in addition to EHB. The Department notes that implementation of this policy has been the subject of considerable confusion over the years, and that has been our observation, as well.

HHS now proposes that a benefit already covered in a state's EHB benchmark plan will be treated as EHB — and therefore will not be subject to state defrayal — regardless of whether the benefit is covered as a result of a mandate enacted after the 2011 cutoff date. We support this proposal. We believe this change should make it easier for everyone to understand what benefits constitute EHB, help state regulators ensure that patients and consumers receive the protections that attach to benefits designated as EHB, and facilitate decision-making by state policymakers seeking to ensure a robust benefit package for marketplace consumers.

Essential Health Benefits: Standards for EHB Benchmark Plan Selection

The Department proposes several changes to the standards that a state must follow should it choose to update its EHB-benchmark plan. We have been pleased to see nine states augment their benchmark plans in recent years to address gaps in covered benefits and believe additional states should consider updating their benchmarks to ensure they are sufficiently robust to meet the needs of consumers.

In our view, the Department's proposals would facilitate these efforts by reducing burdens on states during the EHB-benchmark plan selection process. In a similar vein, we anticipate these changes would help to clarify state policy options and make the benchmark selection process more accessible, which may promote greater public engagement. Therefore, we encourage HHS to finalize these modifications as proposed.

⁶ Giovannelli J, Schwab R, Lucia K. State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>. Published July 28, 2021.

Essential Health Benefits: Coverage of Adult Dental Benefits

The Department proposes to remove the regulatory provision that prevents adult dental services from being treated as EHB. We support this change. We believe the existing rule is not well-supported by the statute and, as a policy matter, does not well-serve patients and consumers. The prohibition has helped perpetuate a false distinction between oral health and the health of the rest of the person and between the oral health of children and adults that can lead adult patients to forgo needed services and potentially experience worse health outcomes. We thank HHS for moving to eliminate this unnecessary barrier to care.

Essential Health Benefits: Coverage of Prescription Drugs

The current EHB standards governing prescription drugs require plans to the greater of one drug per U.S. Pharmacopeia (USP) Medicare Model Guidelines (MMG) class and category or the number of such drugs included in the state's benchmark plan. This standard has not been updated since the EHB rules came into effect in 2014 and has proven to be inadequate to the needs of many patients we represent.

The Department proposes to transition from the USP MMG to the USP Drug Classification (DC) system, and we support this change. For purposes of the EHB framework and the consumers it is intended to serve, the USP DC is superior to USP MMG: the DC system includes additional drug classes needed by the broader patient population served by EHB and is updated more frequently. To support this policy change, we suggest that HHS adopt an annual process, specific to EHB regulation, that reviews the DC system to ensure it remains updated for patients' evolving needs. Such a review should include feedback from patients and consumers.

In addition, the Department could further strengthen the prescription drug standard by requiring coverage of a minimum of two drugs per USP class and category or the number covered by the benchmark plan, whichever is greater, as well as "all or substantially all" drugs in certain specified classes that are critical to vulnerable populations, an approach similar to that adopted under Medicare Part D.

The proposed rule also clarifies that, in the event a plan covers prescription drugs in excess of the minimum number covered by the state's EHB-benchmark plan, the additional drugs are considered EHB. HHS states that this is not a policy change but rather a clarification of this longstanding rule. We greatly appreciate this clarification — which, we believe, constitutes a straightforward and plain reading of the existing regulation. As there should be no confusion regarding a plan's obligations under these provisions, we urge the Department to take enforcement action in the event of future noncompliance.

Special Enrollment Periods: Monthly SEP for Individuals with Household Incomes at or Below 150% FPL

Existing regulations allow for a special enrollment period (SEP), available on a monthly basis, for qualified individuals with household incomes at or below 150 percent FPL. We strongly supported the adoption of this SEP, which we believe is a critical component of a broader consumer-focused strategy to reduce barriers to coverage. We understand this opportunity to be particularly significant for the target population of low-income consumers because it makes transitions from Medicaid to the marketplace — a traditionally challenging and often unsuccessful experience resulting in high levels of coverage loss — relatively easier. The ease of this transition is especially important now given the end of the Medicaid continuous enrollment provision. The proposed rule documents the substantial coverage take-up attributable to this SEP so far, which we believe constitutes strong evidence of its benefits for

consumers and the marketplaces more generally. We applaud the Department for proposing to ensure the policy continues without interruption and strongly support that proposal.

Autoenrollment and Catastrophic Plans

Currently, unlike other marketplace enrollees, individuals in catastrophic plans whose plan has been discontinued and who don't select a new plan are not automatically enrolled in another plan. The proposed rule would require marketplaces to automatically reenroll individuals who lose coverage under a catastrophic plan into a bronze plan in the same product and with a network similar to their discontinued plan. Our organizations support revising the enrollment hierarchy to include individuals in catastrophic coverage and reduce the risk that these enrollees go uninsured. However, we urge the Department to revise this approach so that individuals eligible for cost-sharing reductions (CSRs) are enrolled in a CSR plan if the net (post tax credit) premium would be equal or less than net premium in bronze plan and the network is similar. Additionally, if individuals are not CSR-eligible, the enrollment hierarchy should still enroll them in the highest coverage level plan that has a net premium equal to or less than the net bronze plan premium and has similar network. These revisions would help to ensure that individuals end up in the most affordable, comprehensive coverage available to them.

State Flexibility to Use Income and Resource Disregards for Non-MAGI Medicaid Eligibility

Our organizations agree that the proposal to allow states to provide more targeted income and resource disregards for non-MAGI Medicaid eligibility groups could lead to some states expanding eligibility for certain discrete subpopulations within an eligibility group. However, while the preamble significantly downplays the risk, we believe this proposal could also lead to some states narrowing existing disregards within an eligibility group, thereby restricting eligibility for some individuals relative to current law. State have adopted an extensive array of income and asset disregards since the 1902(r)(2) regulations were promulgated and the 2001 guidance was issued. Facing budgetary or other pressures to reduce enrollment and lower Medicaid costs, some states could use the proposed change to scale back current disregards by restricting their availability only to certain subpopulations. Notably, while the preamble notes that the subpopulation must be defined in a reasonable manner and cannot violate other Federal statutes including anti-discrimination laws, such protections are not included in the revised regulations. To avoid any harmful impact, this new flexibility should only be permitted if the purpose is to increase eligibility relative to current income and resource standards and methodologies. Alternatively, the flexibility should only be permitted if states agree to maintain income and resource disregards for non-MAGI eligibility groups already in effect. Otherwise, the proposal should not be finalized.

Issuer User Fee Rates for the 2025 Benefit Year

HHS proposes that the 2025 user fee rates for issuers that participate on the FFM or an SBM-FP will be 2.2 percent and 1.8 percent, respectively. While we understand this would be a continuation of the fee rates in effect in 2024, we note that such rates are much lower than has been typical throughout the history of the program; with respect to the FFM, the fee rate is substantially smaller than in all previous years.⁷

⁷ The user fee rate for FFM issuers was 3.5 percent from 2014-2019; 3.0 percent in 2020-2021; and 2.5 percent in 2022-2023. HHS did not charge a user fee for issuers on the SBM-FP until 2017. The fee rate for SBM-FP issuers was 1.5 percent in 2017; 2 percent in 2018; 3 percent in 2019; 2.5 percent in 2020-2021; and 2.25 percent in 2022-2023.

We are grateful for the extensive efforts undertaken by the administration to support the work and purpose of the marketplaces. This includes substantially increasing spending on consumer outreach and education, following years in which funding for these vital responsibilities dramatically decreased. As we have in the past, we urge HHS to maintain and expand these investments, and to consider devoting additional resources to improving the HealthCare.gov interface, which would benefit consumer decision-making and facilitate enrollment for health plans. To help sustain the progress of the marketplaces and support the record number of consumers now enrolled in coverage through the portals, we suggest that user fee rates be returned to pre-2022 levels.

Conclusion

Thank you for the opportunity to provide these comments. If you have any questions, please contact Hannah Green with the American Lung Association at hannah.green@lung.org.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
CancerCare
Child Neurology Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Immune Deficiency Foundation
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Eczema Association
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Psoriasis Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society