



July 27, 2023

The Honorable Xavier Becerra  
 Secretary  
 U.S. Department of Health & Human Services  
 200 Independence Avenue, S.W.  
 Washington, D.C. 20201

**Re: Patient Priorities for the Notice of Benefit and Payment Parameters**

Dear Secretary Becerra:

Thank you for your ongoing efforts to ensure the effective implementation of the patient protections and consumer-focused policies of the Affordable Care Act (ACA). We write to express our strong support for this critical work and to offer input we hope will be of assistance in future rulemaking for the 2025 plan year and beyond.

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 ACA. Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

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

We deeply appreciate the administration's commitment to improving the accessibility, affordability, and adequacy of care for all patients and are grateful for the hard work already undertaken to advance these shared goals. As this work continues, in rulemaking for the 2025 Notice of Benefit and Payment Parameters (NBPP) and beyond, we offer the following recommendations.

### **Standardized Health Plans**

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.

To maximize the consumer benefits of plan standardization, we encourage the Department to take additional, complimentary actions for the 2025 plan year.

First, **our organizations recommend that standardized plans be required in all ACA marketplaces.** This includes the state-based marketplaces where a state-designed standardized plan program does not exist. We believe this is particularly important because some states currently using HealthCare.gov may transition to their own enrollment platforms in the future. Consumers in these states should not be allowed to lose access to standardized plans because of a marketplace transition.

Second, **we strongly support the Department's decision to limit the number of non-standard plans that insurers can offer through the marketplaces in 2024 and to strengthen this policy beginning in 2025.** 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 now inhibits consumer decision-making. This year, marketplace shoppers were tasked with choosing among well over 100 plans, on average. This environment favors the sophisticated insurers whose business it is to design health plans, at the expense of 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.

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<sup>1</sup> Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/0912cd7f-c2f9-4112-aaa6-f54d690d6e65/ppc-coalition-principles-final.pdf>.

The 2024 NBPP final rule recognized this problem and adopted a commonsense solution: in the 2024 plan year, insurers will be limited, in a given service area, to four non-standardized plan options per product network type, metal level, and inclusion of dental and/or vision benefit coverage. By rule, this limit will be adjusted to two non-standardized plan options for 2025 and subsequent years. We strongly believe that adopting a tighter limitation in 2025 is necessary to reduce the risks of choice overload while making it easier for consumers to make informed choices for themselves. As we have noted previously, this approach is consistent with how states have implemented standardized plan programs and there is no indication whatsoever that these limits have reduced competition, insurer participation, or plan innovation.<sup>2</sup> 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.

Third, because the choice environment so favors insurers over consumers, we ask HHS to implement other policies designed to help consumers better understand and differentiate between their coverage options. **We encourage the Department to prioritize the display of standardized plans on HealthCare.gov, and to reestablish standards that require an insurer's marketplace plans to be meaningfully different from each other.** It is hard to see any sort of benefit to consumers of two near duplicate non-standard plan offerings (per insurer, per metal tier, per network type), or of a non-standard plan that has been crafted to deviate only slightly from the standard design. In both scenarios, similar but non-identical designs are likely to burden the shopping experience while failing to provide unique value for consumers.

Fourth, **our organizations strongly support efforts by HHS to use standardized plans as a tool for reducing the risk of health disparities and advancing health equity.** We note that 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.<sup>3</sup> We suggest the Department consider these efforts, and closely examine other similar opportunities, when developing plans for 2025 and beyond.

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.

#### **Outreach and Enrollment: Navigator Program**

Resources that help consumers understand and select health care coverage are an essential component of any health care system. Survey work by KFF found that 94 percent of consumers who received individual market enrollment assistance reported it was helpful; approximately 40 percent said it was

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<sup>2</sup> 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.

<sup>3</sup> 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.

unlikely they would have gotten coverage without it.<sup>4</sup> As HHS recognizes, Navigators are trusted partners in their communities and, because of that, are uniquely positioned to help those they serve. By providing free, unbiased, and culturally competent assistance, educating individuals about health insurance and their coverage options, and facilitating enrollment through the marketplace, Navigators promote take-up of comprehensive coverage and contribute to producing a healthier, balanced risk pool.

Since taking office, the administration has demonstrated its strong commitment to the Navigator program, and we are grateful for it. **We urge that investments in the Navigator program grow in future years and encourage the Department to continue to prioritize outreach and enrollment assistance for individuals from marginalized and underserved groups.** These individuals make up a significant share of individuals who are eligible for coverage in the marketplaces or Medicaid but not yet enrolled, which suggests greater investments will improve health equity by reducing barriers to coverage. As part of these efforts, our organizations also urge the Department to assess cultural and language barriers to enrollment, including an examination of whether their materials in languages other than English are easily accessible and whether the content needs to be improved.

In addition, **we recommend that the Department reinstate the remaining community- and consumer-focused program requirements** that were eliminated when Navigator funding was scarce and consider establishing additional standards to prevent the assister-consumer relationship from being undermined. In particular, we suggest that marketplaces again be required to have at least two Navigator entities, at least one of which must be community-based and consumer-focused, and have a physical presence in the marketplace's service area. **We also request that Navigators be expressly prohibited from referring the individuals they serve to debt collection,** conduct which is wholly afield from, and contrary to, their consumer assistance responsibilities.

#### **Outreach and Enrollment: Coordination Between the Marketplaces and Medicaid**

We appreciate the administration's extensive work to ensure access to comprehensive coverage during the COVID-19 public health emergency, through policies that safeguarded and strengthened job-based coverage, the marketplaces, Medicaid, and the Children's Health Insurance Program (CHIP). Earlier this year, states resumed their regular processes for renewing Medicaid enrollees' coverage, which will result in the disenrollment of individuals no longer eligible for the program.

Unfortunately, as you know, initial data suggest that some states are removing large numbers of people from Medicaid for procedural reasons and many of these individuals may in fact still be eligible for the program.<sup>5</sup> It is also unclear at this time the extent to which people losing Medicaid are able to transition smoothly to another source of coverage, including the marketplaces. This is deeply concerning. **We strongly urge HHS to adopt in full the recommendations for improving transitions between Medicaid and the marketplace that many of our organizations previously submitted.**<sup>6</sup> These include sharing information with Navigators, maximizing opportunities to pre-populate applications with information

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<sup>4</sup> Pollitz K, Tolbert J, Hamel L, et al. Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need. KFF. <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>. Published August 7, 2020.

<sup>5</sup> KFF, Medicaid Enrollment and Unwinding Tracker. <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/>. Accessed July 2023.

<sup>6</sup> See Objective 2, Question 3, Health Partner Comments on Request for Information: Access to Coverage and Care in Medicaid and CHIP. April 18, 2022. Available at: [https://www.lung.org/getmedia/e339447c-cfa0-4bc1-bdd5-4a0f4818a2c0/ppc-medicaid-access-rfi-4-18-22-\(final\).pdf](https://www.lung.org/getmedia/e339447c-cfa0-4bc1-bdd5-4a0f4818a2c0/ppc-medicaid-access-rfi-4-18-22-(final).pdf).

included in file transfers, and exploring possibilities for auto-enrollment in \$0 premium plans. We believe these policies are essential for the patients we represent not only during the unwinding, but over the long-term, and **we encourage HHS to require that improvements to the transition process apply in all states and marketplaces (including the state-based marketplaces) to the fullest extent possible.**

### **Standards for Web-Brokers and Other Direct Enrollment Entities**

We recognize that insurance agents and brokers, including web-brokers, can and often do work constructively to help individuals understand their health insurance options and have enrolled many in comprehensive coverage. Yet these entities are also subject to inherent conflicts of interest that are simply not present for Navigators or the marketplaces themselves.<sup>7</sup> Agents and brokers generally have no duty to act in the best interest of consumers and, indeed, are compensated in ways that typically do not align with consumer interests and provide a financial incentive to steer people to products that are unlikely to meet their needs.

We appreciate the recent steps taken by the Department to improve web-broker website transparency and mitigate the risks posed by web-broker conflicts of interest. In our view, however, more action is needed. **HHS should prohibit agents and brokers that sell marketplace plans from marketing products that are not compliant with the ACA’s individual market reforms (such as short-term limited duration products) during marketplace open enrollment. The Department should also require brokers to act in the best interest of the individuals they serve,** as consumers rely on them for their professional experience and expertise. **Agents and brokers should also have an affirmative duty to screen consumers for Medicare and Medicaid eligibility,** so that individuals who qualify for such coverage are not instead routed to private insurance products, as sometimes happens now.<sup>8</sup> In addition, given the risks posed by their financial conflicts, **agents and brokers should also be required to disclose the amount of their commissions.**

Finally, **HHS should consider establishing an assessment for direct enrollment and enhanced direct enrollment entities,** to reflect the special benefits these entities derive from the ACA marketplace structure and regulatory framework. The funding generated from such an assessment could be reinvested in the marketplaces, to the benefit of stakeholders and consumers.

### **The HealthCare.gov Shopping Experience**

A core goal of the ACA’s marketplaces was to make simpler the process 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. We appreciate your efforts to improve the federal shopping portal, HealthCare.gov, which we believe has made great strides over time. **We encourage the Department to continue to upgrade the shopping experience by refining HealthCare.gov’s consumer support tools and improving information display and clarity.** For example, while HealthCare.gov currently provides a total cost estimator, based on the general level of care (low/medium/high) a consumer expects to use during the year, this tool should be updated to offer consumers the option to further customize their anticipated care use (for example, by accounting for prescribed medications or expected medical procedures). We also suggest

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<sup>7</sup> Corlette S, Blumberg LJ, Wengle E. Insurance Brokers and the ACA: Early Barriers and Options for Expanding Their Role. The Urban Institute. <https://www.urban.org/sites/default/files/publication/39571/2000091-Insurance-Brokers-and-the-ACA.pdf>. Published February 2015.

<sup>8</sup> Straw T. “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>. Published March 15, 2019.

that the health plan highlights interface should more prominently and clearly display information regarding mental health services and utilization management requirements for medications.

In addition, **we ask the Department to consider how it may improve website and call center accessibility, including for individuals who are limited English proficient.** We believe existing language access requirements should be elaborated and strengthened for all marketplaces and that additional federal guidance regarding, or coordination of activities and resources to promote access (translations, for example) would benefit consumers.

### **Protections for Consumers in States Transitioning to a State-Based Marketplace**

In no small part because of the administration's commitment to HealthCare.gov, millions of consumers now rely on the federal marketplace to access affordable, comprehensive health insurance. Coverage gains in states served by Healthcare.gov are a significant accomplishment. As you know, some states whose residents have until now benefited from HealthCare.gov plan to shift off the federal marketplace to a state-run platform, and policymakers in additional HealthCare.gov states are considering such a transition. While we strongly believe state-based marketplaces (SBMs) can play — and the existing SBMs have played — a vital role in improving access to quality coverage, we believe equally that **states seeking to assume responsibility for running their own marketplace must demonstrate that this transition will further the goals of the ACA, and we recommend that the Department codify additional policies around SBM transitions in the 2025 NBPP to achieve this goal.**

ACA marketplaces are, fundamentally, neutral platforms for enrolling in comprehensive coverage compliant with the health law's individual market reforms. Marketplaces cannot be used to access products that do not adhere to these federal protections, nor is it permissible for these platforms to be wholly supplanted by private enrollment entities. More than this, any state electing to operate a marketplace at this stage — a full decade into a now-mature program — should be obligated to maintain enrollment gains and eventually expand take-up of comprehensive coverage. And it should be required to articulate, in detail, its plans for fulfilling these responsibilities before being entrusted with them. For example, states should need to commit to adequately funded outreach and enrollment activities and other forms of consumer support to ensure enrollment gains can be maintained.

Similarly, **it is essential that consumers are not made worse off by a state's decision to run its own marketplace.** The ACA's marketplace establishment provisions do not license state policy variation for its own sake. Marketplaces and marketplace policy must serve the best interests of the consumer. Accordingly, transitions that deprive residents of access to consumer-friendly programs and protections that they currently benefit from through HealthCare.gov are deeply concerning. To avoid such backsliding, we urge the Department to extend federal baseline protections to all marketplaces. For example, SBMs should be required to establish standards for network adequacy and brokers that meet or exceed a federal minimum, and all marketplaces should have a standardized plan program (as the vast majority already do).<sup>9</sup> To be clear, what we suggest is a federal floor. SBMs should not be required, for example, simply to copy federal standardized plan program parameters. But a consumer should not be required to forgo federal minimum protections simply because their ACA marketplace changes hands.

Finally, **we request that the marketplace transition process be made more transparent and include formal opportunities for public input.** Marketplace transitions have significant implications for

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<sup>9</sup> These recommendations mirror those made elsewhere in this letter.

consumers and stakeholders. Yet states are under no obligation to solicit comment from the general public on their transition plans. Indeed, key transition documents, including the marketplace Blueprint, are not required to be made public and are rarely released in a timely manner. Whatever the purpose of this approach in the early days of marketplace implementation, we strongly believe that at this point, greater transparency and public input is likely to substantially improve state transition planning. We therefore urge HHS to require states seeking to run their own marketplace to solicit public comment on their Blueprint prior to any federal determination on the transition.

### **Individual Coverage HRAs**

In 2019, the administration finalized a rule that expanded the use of health reimbursement arrangements (HRAs). Prior to the rule, employers could only offer an HRA to employees that enrolled in the employer's group health plan subject to ACA protections. The final rule allows employers to offer an HRA to employees in lieu of a group health plan as long as it is used to buy an ACA-compliant individual market plan. The Individual Coverage HRA (ICHRA) final rule includes limits designed to deter employers from using the offer of an ICHRA to steer older or sicker employees to the individual market while providing less costly employees with a traditional group health plan.<sup>10</sup> However, we have concerns that employers could potentially use the job classifications upon which employers may base their offer decisions as a proxy for health status. Doing so would put higher cost individuals at risk of less comprehensive, more costly coverage than they might have under a group health plan. An influx of higher cost individuals into the marketplaces could also destabilize premiums in that market.<sup>11</sup>

Thanks to prior rulemaking, we have an opportunity to learn more about employers' decisions about the employees offered an ICHRA. Beginning next year, insurers will have to report enrollee-level External Data Gathering Environment (EDGE) data for individuals that have used an ICHRA. **We urge HHS to ensure insurers are using good faith efforts to obtain that information where they don't already have it, and to make this data as transparent and accessible as possible to researchers and others seeking to understand how this new coverage option is being implemented and to evaluate the effectiveness of the non-discrimination guardrails and the overall effect on the individual market.**

### **Patient Cost-Sharing**

Health plans with high out-of-pocket costs, including high deductibles, discourage timely access to needed care, and expose patients to sometimes severe financial burdens and medical debt. High cost-sharing poses a major barrier to care across the spectrum of private health insurance, but its burdens are disproportionately felt in the individual market. Despite the availability of cost-sharing reduction subsidies for low-income marketplace consumers — which provide critical assistance for those under 200 percent of the federal poverty level — the Commonwealth Fund has estimated that more than 40 percent of individual market enrollees in 2020 were underinsured.<sup>12</sup>

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<sup>10</sup> Volk J, Lucia K. Federal Rule Creating New Health Coverage Option for Employers Could Destabilize the Individual Market. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2019/federal-rule-destabilize-individual-market>. Published July 24, 2019.

<sup>11</sup> Young C L, Levitis J, Fielder M. Evaluating the Administration's Health Reimbursement Arrangement Proposal. USC-Brookings Schaeffer Initiative for Health Policy. [https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young\\_Levitis\\_Fiedler\\_HRA-paper\\_12.11.18.pdf](https://www.brookings.edu/wp-content/uploads/2018/12/Linke-Young_Levitis_Fiedler_HRA-paper_12.11.18.pdf). Published December 2018.

<sup>12</sup> Collins SR, Gunja MZ, Aboulaflia GN. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>. Published August 19, 2020.

**We encourage HHS to use its authority to ease the burdens of high out-of-pocket costs by allowing patients to spread those costs over the plan year, rather than be forced to incur them at once, or in large chunks early in the year.** The Inflation Reduction Act (IRA) lets Medicare Part D beneficiaries elect to spread their out-of-pocket limit over 12 months. Similarly, states that have established cost-sharing caps on prescription drugs — whether for a particular drug, such as insulin, or more broadly, for specialty drugs or all covered prescriptions — typically have done so by limiting monthly spending. Marketplace insurers could and should be required to allow enrollees to prorate their out-of-pocket limit and deductible by month. As under the IRA, this option could be made available not just during open enrollment, but throughout the year.

### **Risk Adjustment**

Our groups have previously commented on proposed changes to the risk adjustment program that, amongst other consequences, could have raised premiums for enrollees with higher health needs, and we appreciate that these changes were not finalized.<sup>13</sup> Additionally, **we also urge HHS to continue to refine the risk adjustment program to ensure it is working as intended.** Even though a primary aim of risk adjustment is to make insurers agnostic with respect to the relative health status of their enrollees, we are concerned that at present, the program may inadvertently discourage insurers from offering more generous plans in order to avoid enrolling higher-risk individuals. We ask that HHS consider whether changes to the program are necessary to correct this problem.

### **Essential Health Benefits**

The ACA's standards obligating insurers to cover all essential health benefits (EHB) are of fundamental importance to the patients we represent. We thank the Department for its commitment to ensuring access to comprehensive coverage and preventing discrimination in benefit design. We also appreciate the recent issuance of a Request for Information to inform future rulemaking about EHB. We summarize, here, our recommendations regarding EHB and refer the Department to our full letter in response to the RFI for additional context.<sup>14</sup>

#### *Review of the EHB Framework*

**We urge the Department to update and strengthen EHB standards to ensure plans cover all of the benefits and services patients need.** In order to conduct a thorough and regular review of EHB, HHS should establish a process that is evidence-based, transparent, operates with clearly articulated timeframes for reviewing and reporting, allows for public input, and includes consumer and patient representatives. Such a review would identify barriers to accessing services due to coverage and cost, changes in medical evidence and scientific advancement, and any gaps in coverage for needed services. **We believe strongly that the Department must obtain data from insurers to identify gaps in coverage rather than put the burden on consumers to identify and report those gaps.**

#### *Coverage Gaps*

Our organizations have identified a number of areas where clear coverage gaps exist that need to be addressed for the patients we represent. First, there have been important changes in science and medical advancement since 2014 that are not reflected in current EHB standards. For example, developments in precision medicine over the past decade have greatly expanded the need for

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<sup>13</sup> Health Partner Comments on Notice of Benefit and Payment Parameters for 2023. January 27, 2022. Available at: <https://www.lung.org/getmedia/aef95452-ad4d-4a9c-b6bf-900b33d0e947/012722-PPC-2023-NBPP-Comments-FINAL.pdf>.

<sup>14</sup> Health Partner Comments on Request for Information on Essential Health Benefits. Jan. 30, 2023. Available at: <https://www.lung.org/getmedia/ed8e0797-4fac-4ebc-bbf6-78d184cb3535/PPC-EHB-RFI-Comments-FINAL.pdf>.



comprehensive biomarker testing, in particular for the patients we represent. However, because biomarker testing is not included in the current benchmark documents, there is no clear guidance for plans on coverage of this important medical advancement. **We urge the Department to review the evolving evidence proving the clinical utility of biomarker testing across disease states and provide additional guidance on the scope of insurers' coverage requirements under the laboratory services category of EHB.**

Second, plans currently satisfy EHB standards for prescription drugs if, among other things, they cover the greater of one drug per U.S. Pharmacopeia Medicare Model Guidelines (USP 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. **Our organizations support transitioning to the USP Drug Classification (USP DC) system**, with the recognition that this will not be sufficient to address all the challenges faced by our patients. This change should also be paired with other reforms to bolster the prescription drug coverage standard. **The Department could strengthen this 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 (similar to the approach adopted in Medicare Part D).**

Finally, plans subject to EHB cannot impose a single, combined limit on habilitative and rehabilitative services and devices and, if limits are used, those that apply to habilitative services and devices cannot be less favorable than those that apply to rehabilitation. These are important protections, yet, there is insufficient data on service use to determine compliance with the letter and spirit of the rules.<sup>15</sup> In addition, it appears that the structure of benefit limits, which are often applicable to a specified time period (e.g., the calendar year), should be revisited. **We suggest that such limits, if used at all, should be tied to a particular condition or episode of care, to ensure that patients with multiple conditions can access care sufficient to address their multiple needs.**

#### *Barriers of Accessing Services*

While utilization management can help act as a safeguard for patients receiving appropriate care in an appropriate setting, it can often act as a barrier to necessary care. In reviewing EHB, **we urge the Department to ensure any utilization management is grounded in medical and scientific guidelines and is not used as a tool to restrict access to EHB.** EHB's promise of providing access to a comprehensive set of benefits will be seriously undermined if insurers are able to use plan rules and care review programs to limit access to those services. Additionally, **we urge the Department to consider the role of algorithms in limiting care to certain populations.**

#### *Oversight and Enforcement*

**We ask the Department to ensure that sufficient resources are devoted to enforcing existing EHB standards.** This includes ensuring timely oversight in the states in which the Department directly enforces ACA protections. But, critically, it also includes increased support for the states that are serving as primary regulators *and for residents of all states* who, understandably, may not know where to go to get help for a problem with their ACA-compliant coverage. The Department should more fully realize a "no wrong door" approach for consumers by working with state partners to make it easier for

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<sup>15</sup>Letter from Habilitative Benefits Coalition to Administrator Brooks-LaSure. January 27, 2022. Available at <https://habcoalition.files.wordpress.com/2022/02/hab-comments-on-2023-proposed-nbpp.pdf>.

consumers to figure out who to contact, and providing smooth transfers from one agency to another, for people who initially seek help in the wrong place.

### **Network Adequacy**

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.

Last year's NBPP final rule clarified that appointment wait time standards would take effect beginning with the 2025 plan year. **We appreciate this commitment to wait time standards and look forward to full implementation of these important safeguards in 2025. As we have stated previously, we believe enforcement of these standards must include proactive efforts to test plans' compliance.** We strongly supported the Department's recent proposal to use "secret shopper" surveys to assess Medicaid managed care organizations' adherence to network adequacy wait time standards. We urge the Department to adopt this compliance tool for marketplace plans as well. We believe a proactive approach to network adequacy review is more likely to reveal problems and facilitate timely remediation than is a reactive approach focused only on complaint reporting. To the extent plans are unable to comply with their network adequacy obligations and can provide adequate justification for their noncompliance (as permitted under federal rules), we ask that these justifications be made public in a timely manner.

As you consider how to improve network oversight further, **we urge 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.<sup>16</sup> 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

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<sup>16</sup> See Health Partner Comments on Request for Information: Establishing a National Directory of Healthcare Providers and Services. Dec. 6, 2022. Available at: <https://www.cff.org/media/28011/download?inline>.

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.

Finally, we reiterate our concern that, despite the fact that it is a federal obligation for marketplace plans to maintain adequate networks, the standards and compliance regimes for ensuring network adequacy vary substantially across the states. Under the ACA, a marketplace consumer's ability to access an adequate network of providers should not depend on what state she lives in. **We therefore encourage the Department to extend federal baseline quantitative standards to all marketplaces, federal and state-run alike.** Just as with many other ACA consumer protections, states could retain flexibility to apply and enforce standards that are more stringent than the federal minimum. But marketplace issuers in all states should be accountable for ensuring their enrollees have an adequate network as promised by federal law.

### **Workplace Wellness**

Our organizations have long had concerns with workplace wellness programs. They are largely ineffective in promoting health or lowering health care costs, and instead shift costs to those in poorer health. A 2013 study of wellness programs found they made no significant impact on health care spending or utilization.<sup>17</sup> While a 2019 randomized control trial of a multi-site workplace wellness program found higher rates of reported exercise for the individuals in the wellness program, there was not significant difference in clinical measures of health or healthcare spending and utilization between the group in the wellness program and the group not in the wellness program.<sup>18</sup> Another large-scale, randomized study found workplace wellness programs produced no significant effect on health expenditures, health behaviors, employee productivity, or self-reported health status.<sup>19</sup> Studies have also shown that savings from programs that tie rewards or penalties to achievement of certain health outcomes may shift health care costs to lower-income workers and workers in poorer health rather than reducing plan spending overall.<sup>20</sup>

Research also shows that tobacco surcharges, currently allowable in the individual market, do not work. Most smokers did not quit smoking, but rather, due to the increased premiums, went without health insurance.<sup>21</sup> Additionally, almost half of small employers that used the tobacco surcharge did not offer the required tobacco cessation counseling to help those individuals quit.<sup>22</sup>

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<sup>17</sup> Soeren Mattke, Hangsheng Liu, John P. Caloyeras, et al, "Workplace Wellness Program Study: Final Report," The Rand Corporation, 2013, accessed at:

[https://www.rand.org/content/dam/rand/pubs/research\\_reports/RR200/RR254/RAND\\_RR254.pdf](https://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf)

<sup>18</sup> Song Z, Baicker K. Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes: A Randomized Clinical Trial. *JAMA*. 2019;321(15):1491–1501. doi:10.1001/jama.2019.3307

<sup>19</sup> Jones D, Molitor D, Reif J. What do Workplace Wellness Programs Do? Evidence from the Illinois Workplace Wellness Study. NBER Working Paper 24229.

[https://www.nber.org/system/files/working\\_papers/w24229/w24229.pdf](https://www.nber.org/system/files/working_papers/w24229/w24229.pdf). Published June 2018.

<sup>20</sup> Horwitz J, Kelly B, DiNardo J. Wellness Incentives in the Workplace: Cost Savings through Cost Shifting to Unhealthy Workers. *Health Affairs* Vol. 32, No. 3. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0683>. Published March 2013.

<sup>21</sup> Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up And Did Not Increase Smoking Cessation Abigail S. Friedman, William L. Schpero, and Susan H. Busch *Health Affairs* 2016 35:7, 1176-1183

<sup>22</sup> Nearly Half Of Small Employers Using Tobacco Surcharges Do Not Provide Tobacco Cessation Wellness Programs Michael F. Pesko, Jaskaran Bains, (Johanna) Catherine Maclean, and Benjamin Lê Cook *Health Affairs* 2018 37:3, 473-481

Additional research shows that individuals who are already healthy participate in wellness programs; these individuals were less likely to have high medical costs.<sup>23</sup> The researchers concluded that wellness programs do not encourage participants to change their behavior, but rather only attract healthy individuals.

Given the poor track record of wellness programs in achieving their goals of promoting health and the potential for discrimination against the patients with serious and chronic health conditions that we represent, we strongly oppose any effort to promote or even allow their use in the individual market. **We therefore ask HHS to rescind the bulletin issued in 2019 inviting states to submit proposals for approval under the ten-state “Wellness Program Demonstration Project to Implement Health-Contingent Wellness Programs in the Individual Market.”** The ACA created a health insurance market that shields patients from discrimination based on health status. The bulletin inviting states to participate in the wellness program demonstration project would undermine those foundational protections. **We also call on HHS to withdraw the rule change that allows issuers to count spending on certain wellness incentives as Quality Improvement Activities (QIA) when calculating their Medical Loss Ratio (MLR), the intent of which was to “ensure...access to wellness programs” under the ten-state wellness program demonstration project.**

### **Conclusion**

Thank you for considering this input. Our organizations would welcome the opportunity to discuss these recommendations with you and your staff. Please contact Hannah Green with the American Lung Association at [hannah.green@lung.org](mailto:hannah.green@lung.org) with any questions. We look forward to partnering with you to advance affordable, accessible and adequate healthcare coverage for patients and consumers.

Sincerely,

Alpha-1 Foundation  
ALS Association  
American Cancer Society Cancer Action Network  
American Kidney Fund  
American Lung Association  
Arthritis Foundation  
Asthma and Allergy Foundation of America  
Cancer Support Community  
CancerCare  
Child Neurology Foundation  
Crohn's & Colitis Foundation  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Foundation for Sarcoidosis Research  
Hemophilia Federation of America

Lupus Foundation of America  
Muscular Dystrophy Association  
National Alliance on Mental Illness  
National Eczema Association  
National Hemophilia Foundation  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Organization for Rare Disorders  
National Patient Advocate Foundation  
National Psoriasis Foundation  
Pulmonary Hypertension Association  
Susan G. Komen  
The AIDS Institute  
The Leukemia & Lymphoma Society

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<sup>23</sup> Jones, D. Molitor, D. and Reif, R., A Reason to Be Skeptical of the Workplace Wellness Industry: New study finds no changes in health care costs. Scientific American. March 19, 2019. Accessed at: <https://www.scientificamerican.com/article/a-reason-to-be-skeptical-of-the-workplace-wellness-industry/>.