



September 13, 2022

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 2024 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)

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

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 2024 Notice of Benefit and Payment Parameters (NBPP) and beyond, we offer the following recommendations.

## **Affordability**

### ***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>2</sup>

We believe that by clarifying existing statutory protections — particularly, the ACA's single risk pool requirement — and enforcing a consistent adherence by insurers to those rules, the Department of Health and Human Services (HHS or the Department) can significantly reduce the burdens of high cost-sharing while also discouraging gaming in the premium rate-setting process.

The single risk pool requirement is a core protection of the ACA, designed to prevent discrimination in premium rate-setting. It does this, in part, by prohibiting insurers from adjusting plan-level premiums except as needed to account for plan-specific differences, including differences in actuarial values and cost-sharing designs.<sup>3</sup> This means, among other things, that more generous plans should have higher premiums than less generous ones, and insurers cannot adjust premiums based on assumptions about the kinds of people it expects will enroll in each type of plan.<sup>4</sup>

Nevertheless, it appears broadly to be the case that premium rate-setting in the individual market has strayed from these rules. The upshot is that plan premiums and plan benefits are often badly misaligned: the premium price of a plan routinely does not reflect the value of the coverage being offered. Silver plans are aggressively underpriced, while gold and bronze plans cost more than they should — more than is actuarially justified or permitted by law.<sup>5</sup>

---

<sup>2</sup> Collins SR, Gunja MZ, Abouafia 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.

<sup>3</sup> 45 C.F.R. § 156.80(d)(2).

<sup>4</sup> Of course, as you know, insurers are permitted to make certain assumptions about the characteristics of individual market enrollees as a whole, as a single risk pool. 45 C.F.R. § 156.80(a), (d); see also HHS, 2022 Unified Rate Review Instructions. [https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/URR\\_v5.3-instructions.pdf](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/URR_v5.3-instructions.pdf).

<sup>5</sup> See, e.g., Dorn S, Fann GG, Markus H. Misalignment Between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges. Families USA. [https://familiesusa.org/wp-content/uploads/2021/04/COV-2021-31\\_Gold-and-Silver-Report\\_4-9-21-002.final\\_.pdf](https://familiesusa.org/wp-content/uploads/2021/04/COV-2021-31_Gold-and-Silver-Report_4-9-21-002.final_.pdf). Published March 2021;

Because of this, it is harder than it should be for many consumers to afford gold plans. Individuals who would be well served by gold-tier coverage pay an inflated premium for it, enroll in a lower-premium silver (or bronze) plan with much higher cost-sharing, or forgo marketplace coverage altogether.

**We recommend that the Department clarify that this rate-setting behavior violates the ACA's single risk pool requirement and provide additional instructions designed to ensure plans are priced in proportion to the value they offer.** A growing number of states, from Maryland to Texas, have recognized this problem and the benefits to consumers of fixing it, and have begun to enforce greater alignment between plan premiums and actuarial value. In New Mexico, this policy resulted in a doubling of the share of people with gold coverage, as enrollees shifted in large numbers from plans with high cost-sharing to relatively low cost-sharing gold plans.<sup>6</sup> Were HHS to act similarly, marketplace consumers across the country would benefit from increased premium assistance and improved access to coverage (gold plans) with more generous cost-sharing.

In addition, **we also 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 recently enacted Inflation Reduction Act (IRA) lets Medicare Part D beneficiaries elect to spread their out-of-pocket limit over 12 months. 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.

## **Accessibility**

### ***Standardized Health Plans***

Standardized health plan designs, as the Department has recognized, offer numerous advantages to patients and consumers. The use of uniform cost-sharing parameters across plans reduces consumer confusion and makes 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, our organizations were pleased the Department will require insurers on HealthCare.gov to offer health plans with standardized cost-sharing parameters beginning in 2023. To maximize the chance that all marketplace consumers are able to realize the benefits of plan standardization, we urge the Department to take additional, complimentary actions for the 2024 plan year.

---

Sprung A and Anderson D. Getting Full Benefit From Silver Loading: How The Biden Administration Can Regulate To Make Care More Affordable. Health Affairs.

<https://www.healthaffairs.org/doi/10.1377/forefront.20210222.921409>. Published February 23, 2021.

<sup>6</sup> Dorn S. How New Mexico Dramatically Reduced Marketplace Deductibles At Zero Cost To The State. Health Affairs. <https://www.healthaffairs.org/content/forefront/new-mexico-dramatically-reduced-marketplace-deductibles-zero-cost-state>. Published July 20, 2022.

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.

Second, **we strongly encourage HHS to limit the number of non-standard plans that insurers can offer through the marketplaces.** As you know, the number of plans offered through the marketplaces has sharply increased in recent years, to a point where many consumers experience not meaningful choice, but “choice overload.” This environment favors sophisticated insurers, not consumers, and can lead to poor enrollment decisions or choice paralysis that discourages enrollment altogether. Placing limits on the number of non-standard plan offerings would allow consumers to more easily sift through their options, identify insurers’ standardized plans, and determine whether those carriers’ non-standard alternatives offer unique value worth paying for. We believe this approach would empower consumers to make better choices for themselves and reduce the risk of sub-optimal enrollment outcomes. Most states that already use standardized plans also limit non-standard offerings to promote consumer decision-making.<sup>7</sup> What’s more, there is no indication whatsoever that these limits have reduced competition, insurer participation, or plan innovation in those markets.

Third, we ask HHS to implement other policies designed to help consumers better understand and differentiate between their coverage options. For example, **HHS should reestablish standards that require an insurer’s marketplace plans to be meaningfully different from each other,** with a focus on rules that ensure the differences between standard and non-standard are clear. **We also encourage the Department to prioritize the display of standardized plans on HealthCare.gov.**

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>8</sup> We suggest the Department consider these efforts, and closely examine other similar opportunities, when developing plans for 2024 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. 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.

---

<sup>7</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>8</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.

### ***Outreach and Enrollment***

Resources that help consumers understand and select health care coverage are an essential component of any health care system. Survey work by the Kaiser Family Foundation found that 94 percent of consumers who received individual market enrollment assistance reported it was helpful; approximately 40 percent said it was unlikely they would have gotten coverage without it.<sup>9</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 were pleased to see the announcement of \$98.9 million in Navigator funding for the 2023 open enrollment period, an increase of nearly \$20 million from the previous year, and **we urge that investments in the Navigator program continue to grow in future years.** We 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.

Finally, the end of the COVID-19 public health emergency (PHE) will be a critical period for enrollment in marketplace coverage. One third of adults who lose Medicaid eligibility at the end of the COVID-19 PHE are estimated to be eligible for marketplace coverage, and the patients our organizations represent in particular need a smooth transition between sources of coverage to appropriately manage their health conditions.<sup>10</sup> In upcoming rulemaking, future guidance, and other activities, **we urge HHS to include the recommendations many of our organizations submitted in response to the April 2022 Request for Information on Access to Coverage and Care in Medicaid and CHIP to improve the transition between Medicaid and marketplace coverage both during as well as beyond the end of the PHE** (Objective 2,

---

<sup>9</sup> Pollitz K, Tolbert J, Hamel L, et al. Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need. <https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/>. Published August 7, 2020.

<sup>10</sup> Matthew Buettgens and Andrew Green. What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency? March 2022. Available at: [https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency\\_1\\_1.pdf](https://www.urban.org/sites/default/files/2022-03/what-will-happen-to-medicaid-enrollees-health-coverage-after-the-public-health-emergency_1_1.pdf).

Question 3).<sup>11</sup> These recommendations included using existing flexibilities to increase the time to enroll in marketplace coverage, expanding partnerships with Navigators, and considering possibilities for auto-enrollment in \$0 premium plans.

### ***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>12</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>13</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

---

<sup>11</sup> 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).

<sup>12</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>13</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.

example, by accounting for prescribed medications or expected medical procedures). We also suggest that the health plan highlights interface should more prominently and clearly display information regarding mental health services and utilization management requirements for medications.

### ***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 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>14</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>15</sup>

The 2023 NBPP gives us an opportunity to learn more about employers' decisions about the employees offered an ICHRA. HHS will collect enrollee-level External Data Gathering Environment (EDGE) data from insurers that includes information on use of an ICHRA. **We urge HHS 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.**

### **Adequacy**

#### ***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, and for acting in recent rulemaking to close a loophole in the EHB framework that had given insurers leeway to reduce access to needed care.<sup>16</sup> **We recommend the Department continue to use its broad authority under the ACA to update and strengthen EHB standards, to ensure plans cover all of the benefits and services patients need.**

Federal rules allow EHB to be defined differently across states, via a benchmarking process that, in its fundamental approach — its deference to states to define what constitutes an "essential" benefit under federal law — has not changed since the ACA's initial implementation. We note that the state benchmark process currently relies on benefit designs that are more than five years old and there are numerous areas in which benefit standards need to be reassessed and likely updated. There are steps

---

<sup>14</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>15</sup> Link Young C, 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>16</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023, 87 FR 27208, 27293-94 (reinstating prohibition on benefit substitution across EHB categories, codified at 45 C.F.R. § 156.115).

that HHS could take as soon as the 2024 NBPP to strengthen these standards. We highlight just some examples here:

- *Prescription drug coverage.* Plans currently satisfy EHB standards for prescription drugs if, among other things, they cover the greater of one drug per U.S. Pharmacopeia (USP) 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. Additionally, some medications on which our patients rely — including, for example, most drugs that treat bleeding disorders, and many cancer and primary immune deficiency drugs — are not part of the USP classifications system, which is used to classify Medicare Part D drugs but does not include Part B drugs. This can make it effectively impossible for a consumer to determine whether a plan provides adequate coverage for their needs. **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). The Department should also clarify coverage requirements for Part B medications.**
- *Habilitative and rehabilitative services and devices.* 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>17</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.**
- *Pediatric services.* The benchmark process preferences plans focused on the health needs of adults and there has been significant variation across state EHB benchmarks in the coverage of benefits and services for children specifically.<sup>18</sup> In the coming year, upon the eventual expiration of the COVID-19 PHE, we expect many families will lose Medicaid, and its robust Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) pediatric benefit, and enroll in marketplace coverage. These transitions will exacerbate the risks posed by gaps in the EHB pediatric services benefit and illustrate why **the current standard should promptly be reassessed and, if necessary, revised.**

In addition to prompt action in these areas, a comprehensive review of the EHB framework is also needed. The ACA directs HHS to periodically review the EHB framework. Under the statute, this review must include a report to Congress and the public that contains, among other things, assessments of (1) whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

---

<sup>17</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>.

<sup>18</sup> Grace AM, et al., The ACA’s Pediatric Essential Health Benefit has Resulted in a State-by-State Patchwork of Coverage with Exclusions. Health Affairs. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0743>. Published Dec. 2014.

and (2) whether EHB must be modified or updated to account for changes in medical evidence or scientific advancement. These provisions of the ACA also explicitly charge the Department with the task of updating benefit requirements to address any gaps in access to coverage or changes in the evidence base that are identified in these reviews. It is our understanding, however, that such a review has never been undertaken. **We urge the Department to begin the process of reviewing the EHB framework, as mandated by the ACA, to determine whether consumers are well-served by the state benchmark approach and to identify areas in which EHB must be updated. Going forward, the EHB framework should be reviewed and updated regularly pursuant to a clearly articulated schedule and in a manner that is transparent to the public.**

We also recommend the Department refine the EHB benchmark selection process to ensure it cannot be exploited to undermine access to comprehensive coverage. While current rules establish guardrails designed to prevent states from adopting a benchmark that is either too generous — the “generosity” test — or too skimpy — the “typical employer plan” test — we remain concerned that these provisions do not well reflect the statutory EHB protections and place consumers at undue risk of benefit gaps. **We suggest tightening the definition of “typical employer plan” to reduce further the likelihood that an outlier plan with insufficient benefits could be used to justify the selection of a skimpy benchmark plan. We also request you consider changes to the “generosity” test, which at present offers less flexibility (in terms of the potential number of comparator plans) than its “typical employer plan” counterpart, and remains tied to plan designs that date back to 2017.**

In addition, **we request that HHS provide explicit protections to ensure continuity of care for enrollees** who transition to a new plan that does not routinely cover their existing course of treatment. For example, the Department might establish a grace period or other transitional relief that would enable patients to carry over or quickly secure authorization for ongoing care. Again, such protections will be particularly important during the widespread coverage transitions at the end of the COVID-19 PHE.

Finally, **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 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 strongly support the Department’s decision to establish a robust set of quantitative, time and distance standards for assessing network sufficiency beginning in the 2023 and appreciate your commitment to implementing appointment wait time limitations in 2024. We believe that establishing standards specifying the maximum number of days enrollees may be required to wait for a provider appointment will add an important dimension to network adequacy review that is not captured by other

network rules. **When appointment wait time standards do come into effect in 2024, we request that the Department take affirmative steps to test plans' compliance.** 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.

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. 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.

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 support extending 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>19</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

---

<sup>19</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)

the group in the wellness program and the group not in the wellness program.<sup>20</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>21</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>22</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>23</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>24</sup>

Additional research shows that individuals who are already healthy participate in wellness programs; these individuals were less likely have high medical costs.<sup>25</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.**

---

<sup>20</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>21</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>22</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>23</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>24</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

<sup>25</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/>

## **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,

American Cancer Society Cancer Action Network  
American Lung Association  
American Kidney Fund  
*CancerCare*  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Hemophilia Federation of America  
Immune Deficiency Foundation  
Lupus Foundation of America  
Muscular Dystrophy Association  
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