



June 7, 2024

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 2026 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 2026 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 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

<sup>1</sup> Consensus Health Reform Principles. Available at: <https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles>

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, we offer the following recommendations for the 2026 Notice of Benefit and Payment Parameters (NBPP), as well as future rulemaking.

### **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>2</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.

In recent months, it has come to light that some agents and brokers have been enrolling consumers in a marketplace plan or switching an enrollee from one plan to another without these individuals' knowledge or consent, in order to obtain additional commissions. This is deeply disturbing. We appreciate the steps the Department has already taken to help consumers affected by this misconduct.<sup>3</sup>

**Our organizations urge you to continue to do everything within your authority to identify every consumer who may have been a victim of an unauthorized enrollment or plan switch, inform them of the potential impact on their coverage, and ensure they are held harmless.**

While helping affected consumers must be priority one, there is much more that must be done to address this serious problem. **Our organizations ask that you establish new safeguards and deterrents against agent and broker misconduct.** Though agents and brokers are required to obtain consent before enrolling a consumer, the magnitude of unauthorized plan switches and enrollments that HHS has documented suggests that either consent is not being verified in a timely manner, before commissions are paid, or that consent is being obtained once for the first plan purchase but not for the subsequent switches to different plans. We recommend the Department require insurers to confirm that a consumer's consent is properly documented each time they are enrolled in a plan before paying a commission. HHS should also implement an automated and timely consumer notification informing them that an agent or broker has made changes to their enrollment and instructing them to contact the marketplace if such activity was unexpected. While neither of these suggestions would eliminate the possibility of fraud by a determined bad actor, and there is unlikely to be any single solution that would do so, we strongly urge the Department to take concrete actions to reduce the risks to consumers and the integrity of the marketplace.

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<sup>2</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>3</sup> CMS. CMS Statement on Agent and Broker Marketplace Activity, Update. <https://www.cms.gov/newsroom/press-releases/cms-statement-agent-and-broker-marketplace-activity-update>. Published May 6, 2024.

**In addition, we believe it is essential that the Department 1) use the enforcement authority it clearly has under law; and 2) work collaboratively with state regulators, to ensure that the perpetrators of these fraudulent enrollment schemes are held fully accountable.** HHS has processes in place to suspend or terminate an agent or broker's authority to enroll marketplace consumers; it can impose substantial civil monetary penalties in cases of fraud or misconduct. HHS should promptly use these tools to address this problem, to ensure accountability and demonstrate that the Department will not tolerate such blatant efforts to exploit consumers. We also strongly urge HHS to coordinate with state regulators on these enforcement efforts to the fullest extent permitted by law. It is equally incumbent on state officials to address these issues, by enforcing state standards governing agents and brokers and other applicable anti-fraud and consumer protection statutes. Increased coordination between the Department and your state partners will empower them to fulfill their oversight and enforcement responsibilities.

More broadly, we note that these recent cases of misconduct are not without precedent. **Our organizations have long been of the view that the federal regulatory structure for agents and brokers does not do enough to mitigate the risk to consumers, and we urge you to take additional steps to protect patients.** 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>4</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, in future rulemaking, 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, including in increased enforcement activities that protect patients and consumers from agent and broker misconduct.

### **Outreach and Enrollment**

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.

Our organizations are grateful for the administration's strong commitment to the Navigator program. The administration recently announced that it plans to award a total of \$500 million in Navigator grants over the next five years. We strongly support this multi-year funding commitment, which promotes long-term planning and budgeting and can help grantee organizations adjust capacity to respond to unexpected or unmet needs. **We encourage the administration to continue to provide multi-year**

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<sup>4</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.

**contracts to support this critical work and to continue to increase the amount of these investments to levels commensurate with the historically high interest in marketplace coverage.**

Last year, following the expiration of pandemic-era protections ensuring continuous coverage for Medicaid enrollees, states resumed their regular processes for renewing Medicaid coverage. More than 22 million people have lost Medicaid coverage as of early June 2024.<sup>5</sup> Moreover, it remains unclear the extent to which people disenrolled from Medicaid have been able to transition smoothly to another source of coverage, including the marketplaces. **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 included in file transfers, and exploring possibilities for automatic or facilitated enrollment in \$0 premium plans (as some states have now done). 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 SBMs) to the fullest extent possible.**

In future rulemaking, our organizations encourage the Department to focus on improving the Healthcare.gov shopping experience, especially website and call center accessibility for individuals with limited English proficiency. As part of these efforts, the Department should 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. We also urge the Department to reinstate the remaining community- and consumer-focused program requirements for Navigators (at least two Navigator entities per state, at least one of which must be community-based and consumer-focused, and Navigators must have a physical presence in the marketplace's service area), and expressly prohibit them from referring the individuals they serve to debt collection.

### **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. Our organizations express our ongoing strong support for 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 2026 plan year.

First, **we recommend that standardized plans be required in all ACA marketplaces**, including all state-based marketplaces (SBMs). We understand and appreciate that the Department does not wish to constrain unnecessarily a state's flexibility in operating its marketplace. A federal minimum requirement regarding standardized plans need not impose such a constraint. HHS could articulate a baseline standard that does not displace, nor affect in any manner, the work that most SBMs have already undertaken to develop and maintain their own standardized plan programs. Rather, we believe that at

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

<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).

this juncture, the primary objectives of a marketplace-wide standardized plan requirement should simply be to ensure that 1) the benefits of these plans are available to consumers in marketplaces without such plans currently; and 2) consumers in states that currently use HealthCare.gov do not lose access to standard plans if their state transitions to an SBM.

Accordingly, while we believe that providing access to standardized plans must be a minimum obligation incumbent on all marketplaces, we do not believe the Department must mandate specific cost-sharing parameters for plans sold through the SBMs. We recognize that consumers may benefit if SBMs are able to customize standardized plan designs; certainly, the SBMs may be particularly well-positioned to determine how best to communicate the value of plan standardization to their consumers and use their enrollment websites to maximize those benefits. We do not suggest that a federal standardized plan rule foreclose these avenues of flexibility.

Second, **our organizations support the current limit on the number of non-standard plans that insurers can offer through the marketplaces and urge that requests for an exception to this limit be closely scrutinized.** 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 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.

We know the Department understands this problem and we appreciate your efforts, in prior rulemaking, to mitigate it. As we have observed in the past, the federal limitation on non-standard plan offerings is a commonsense tool for addressing choice overload that is entirely consistent with how states have approached this issue previously.<sup>7</sup> Such limits on non-standardized plans do not prevent insurers from developing innovative plan designs — there is no indication whatsoever that these limits have reduced plan innovation, let alone insurer participation or market competition. Rather, they ensure that consumers will be better positioned to determine whether such innovations offer unique value.

Earlier this year, HHS finalized a proposal that will allow insurers to apply, in certain circumstances, to offer non-standard plans in excess of the regulatory limit. Our organizations appreciate that, in response to public comments, the Department further elaborated and strengthened the criteria that an insurer must satisfy in order to be eligible for an exception to the non-standard plan limit. We believe the exceptions process, as finalized, is less susceptible to abuse than the process the Department initially proposed. While these improvements are welcome, we remain concerned that allowing insurers any opportunity to avoid the current limit on non-standard plans is of dubious value to consumers. The regulatory limit we are talking about already affords insurers significant leeway to sell a wide variety of plans: as the Department has observed, an insurer that uses just two product network types (e.g., an HMO and PPO) could offer consumers an *unlimited number of standardized plans plus 32 different non-standardized plans, at each metal tier*. Insurers that take advantage of the new exceptions process will be able to spin off still more plan variations, further eroding the consumer benefits of plan standardization. We worry that exceptions requests frequently will not be justified under the

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<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.

Department's rules, and we urge you to closely scrutinize all such requests to ensure that when an insurer exercises this new flexibility, it does so in the interest of consumers.

In future rulemaking, we encourage the Department to expand upon its work on standardized plans with additional patient- and consumer-friendly policies. As we have outlined in previous letters,<sup>8</sup> these include prioritizing the display of standardized plans on HealthCare.gov, reestablishing standards that require an insurer's marketplace plans to be meaningfully different from each other, using standardized plans as a tool for reducing the risk of health disparities and advancing health equity, and using standardized plans to reduce barriers to care posed by excessive cost-sharing.

### **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, including ensuring that marketplace consumers in all states will benefit from concrete federal network adequacy protections beginning in 2026. We also strongly support the Department's decision, in the 2025 letter to federal marketplace 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 are pleased that the results of these surveys must be reported to HHS and that insurers must provide full documentation of this work to the Department on request.

In addition, our organizations appreciate that the Department now requires insurers to report data showing the number of out-of-network claims their enrollees have submitted. This information is useful because, among other reasons, a relatively large number of out-of-network claims may be a signal to regulators that a plan's network is not meeting the needs of its enrollees. **We encourage HHS to use this data to inform oversight and enforcement and to collect additional information — for example, data revealing the types of providers and services for which out-of-network claims are being made — that can help shed light on how networks are working for consumers.**

As you consider how to improve network oversight in future years, we urge the Department to extend the federal baseline quantitative standards to all marketplaces (federal and state-run alike), scrutinize networks for their ability to provide culturally- and linguistically-competent care as well as physically and programmatically accessible care, and continue to strengthen standards for and oversight of marketplace plan provider directories.

### **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.

Federal rules currently prohibit insurers from covering routine adult dental and vision services and long-term/custodial nursing home care benefits as EHB. The Department acknowledged, in the 2025 NBPP,

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<sup>8</sup> Letter to HHS on Recommendations for 2025 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>



that the regulatory prohibition on treating adult dental services as EHB is not required by the ACA and, indeed, unnecessarily restricts consumers' access to such care. The Department thus proposed and ultimately finalized a change to that regulation that allows adult dental services to be included as EHB beginning in 2027. Our organizations thank the Department for facilitating access to oral health services. For broadly the same reasons, **we urge HHS to rescind the regulatory prohibition on adult vision services and long-term/custodial nursing home care.** The categorical exclusion of these services from EHB plainly exceeds what the statute requires and we believe is at odds with the intent of the ACA, inasmuch as it strictly limits (without any scientific or medical basis) the ways in which EHB packages can evolve to meet the diverse health care needs of the population. The patients we serve are often in need of vision and long-term/custodial nursing care, and providing these benefits as EHB would be an important step towards health equity.

Our organizations also thank the Department for recently clarifying federal policy regarding the circumstances in which a state-required benefit will be considered in addition to EHB and require state defrayal of costs. We understand there continues to be confusion in situations where a state's EHB benchmark specifies some, but not all elements of a health benefit and ask that you **consider publishing additional guidance on these issues.**

In future rulemaking, we once again encourage the Department to comprehensively update and strengthen EHB standards to ensure access to adequate coverage and prevent discrimination in benefit design. We refer the Department to our letter in response to its 2022 Request for Information on EHB for specific recommendations.<sup>9</sup>

### **Transparency**

The ACA includes multiple transparency provisions that require all non-grandfathered health plans to report detailed claims and coverage data to HHS, state insurance regulators, and the public. These data (much of which is not otherwise available) can offer critical insight into how people are experiencing their health coverage and illuminate issues of concern that may require regulator intervention or changes in policy. Unfortunately, these provisions have never been fully implemented.

Our organizations recognize and appreciate that this administration has increased data reporting and disclosure requirements for marketplace issuers. **We urge that you continue to build out these reporting obligations, as called for under the statute, and use the information collected to increase transparency and inform oversight and policy development.** We have noted, above, where increased data reporting on out-of-network claims would aid network adequacy regulation. But that is just one area of many where greater transparency can improve regulation and policymaking. We also believe, for example, that collection and reporting of more granular data describing claims denials and appeals (e.g., the reason for the denial or the type of claim at issue) would substantially assist our understanding of where barriers to care are most prevalent and how they might be addressed.<sup>10</sup>

**Our organizations also urge HHS to work with the SBMs to develop and implement best practices for the regular public release of marketplace data.** At present, there is significant variation in the types and

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<sup>9</sup> Comments on Request for Information on Essential Health Benefits. Jan. 30, 2023. Available at: <https://www.protectcoverage.org/siteFiles/43042/01%2030%2023%20PPC%20EHB%20RFI%20Comments%20FINAL.pdf>.

<sup>10</sup> Politz K, Lo J, Wallace R, et al. Claims Denials and Appeals in ACA Marketplace Plans in 2021. KFF. Feb. 9, 2023. Available at: <https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/>.

granularity of data that SBMs publish — regarding enrollment and affordability, for example — and the frequency and timeliness of these releases. The lack of uniformity frustrates cross-state comparisons, which inhibits policy development. These challenges will only grow if additional states transition from the federal marketplace to an SBM.

### **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 never finalized.<sup>11</sup> More broadly, though, **we support HHS in its ongoing efforts 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.

### **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 Heart Association  
American Kidney Fund  
American Liver Foundation  
American Lung Association  
Arthritis Foundation  
Chronic Disease Coalition  
Cystic Fibrosis Foundation  
Epilepsy Foundation  
Hemophilia Federation of America  
Immune Deficiency Foundation  
Lupus Foundation of America  
Muscular Dystrophy Association

National Bleeding Disorders Foundation  
National Eczema Association  
National Kidney Foundation  
National Multiple Sclerosis Society  
National Organization for Rare Disorders  
National Patient Advocate Foundation  
National Psoriasis Foundation  
Susan G. Komen  
The AIDS Institute  
The Leukemia & Lymphoma Society  
The Mended Hearts, Inc.  
WomenHeart

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<sup>11</sup> 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>.