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November 6, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
Room 445–G 200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate this opportunity to respond to the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program proposed rule (RIN 0938–AV41). The AMA appreciates the administration's ongoing commitment to boost consumer protections, expand coverage, improve patient outcomes, advance health equity, and improve marketplace accuracy, transparency, and integrity. We offer detailed comments largely in support of several proposals below, along with some recommendations to further strengthen marketplace coverage.

Enhancing Beneficiary Protections

The AMA strongly supports proposed changes to boost consumer protections, including requiring Marketplaces to notify enrollees who have failed to file their federal income taxes and reconcile their Advance Premium Tax Credit (APTC) for two consecutive years that they are at risk of losing their APTC. In addition, the AMA supports the U.S. Department of Health and Human Services (HHS) conducting its own essential community provider (ECP) certification evaluations of each issuer's network, rather than relying on states to do so thanks to technological improvements that allows HHS to collect ECP data directly from issuers. Both proposals will help to reduce churn and maintain robust coverage and access to care. We urge the Centers for Medicare & Medicaid Services (CMS) to finalize both proposals and execute plans to leverage ECP data to evaluate provider networks and monitor for challenges that could negatively impact enrollee access to care, such as provider shortages or facility closures.

The AMA supports CMS exploring new de minimus payment premium threshold options under which consumers would not lose coverage for owing a relatively small amount of their premiums. Regarding the proposed new fixed-dollar premium payment threshold option, which we support, we believe a larger threshold would help to extend coverage to more individuals while still posing a small financial impact to issuers. Raising the dollar threshold to the proposed alternative of $10 would benefit an additional 21,345 beneficiaries and would have our support. The AMA disagrees with CMS' proposal *not* to apply this

threshold to the initial binder payment to activate coverage for the year based on the logic that "enrollees must always pay some amount of premium to effectuate coverage as an important signal that the coverage is desired by the enrollee." While we generally support the principles of beneficiary choice and engagement, in this case we believe the benefits of maintaining coverage clearly outweigh the need for consumer signaling and do not see merit in eliminating coverage based on failure to pay a nominal fee.

The AMA further disagrees that issuers should have to choose between a fixed-dollar or performance-based threshold and asks that multiple thresholds be allowed to apply, which would help maintain coverage for the maximum number of enrollees. As CMS acknowledges, each threshold has distinct advantages in real-world scenarios that varies not only plan-to-plan, but enrollee-to-enrollee. Since the thresholds are beneficial to enrollees, the AMA does not believe that lack of consistency or uniformity among plans is cause for concern nor a reason to disallow applying multiple thresholds. Similarly, we believe CMS should finalize both the gross and enrollee net percentage-based premium options, as both have individual merits. In the interest of promoting continuous coverage, as well as promoting consistency and uniformity across plans, CMS should consider requiring or incentivizing that all thresholds be applied. This is the surest way to effectively protect against the various scenarios CMS provides in the rule. In any case, prioritizing the least disruption to enrollee coverage should be CMS' paramount consideration in finalizing any threshold changes.

The AMA supports CMS' proposal to specify that an issuer that offers multiple standardized plan options within the same product network type, metal level, and service area must meaningfully differentiate these plans from one another in terms of included benefits, provider networks, and/or formularies. We agree this change will help to simplify the plan selection process and increase consumer understanding, particularly among disadvantaged populations, thereby advancing health equity. In finalizing this new policy, HHS should offer issuers an opportunity to make the case for how the two plans differ before making the decision not to certify one of the plans. Overall, we support CMS' efforts to help consumers understand the difference between plan offerings and agree this is critically important to a well-functioning consumer-friendly insurance marketplace.

The AMA appreciates CMS' efforts to refine risk adjustment to ensure the viability of plans and issuers that serve high-risk populations and protect against selection bias including its comment solicitation on time value of money. Regarding rebate requirements, the AMA appreciates the potential need to extend flexibilities to a small subset of plans that focus on underserved and/or complex populations. The AMA appreciates the targeted nature of the proposal that the new methodology would only apply to a small subset of qualifying issuers. However, CMS fails to disclose how many plans would be impacted or detail the magnitude of the impact on Medical Loss Ratio calculations. It is unclear for example that the proposed 50 percent threshold of net risk adjustment payments to earned premiums appropriately distinguishes a "small subset" of issuers. The AMA believes it is incumbent on CMS to share this type of contextual information so stakeholders can fully evaluate these proposals and the impact they will have.

The AMA appreciates HHS' solicitation comment regarding how navigators and other assisters can refer consumers to programs designed to reduce medical debt. The AMA agrees that medical debt is a serious issue affecting many American families and supports efforts for health organizations to resolve debts with patients directly through strategies such as discounts, sliding-scale, interest-free payment plans, financial aid, and debt forgiveness. The AMA also supports private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation, as well as increased transparency standards for hospitals about patient financial responsibilities, including itemized debt statements. We additionally support general efforts to improve the affordability of insurance coverage, including many of the proposals in this rule, and we look forward to reviewing future policy proposals in this area.

One element that is noticeably missing from the rule regards problematic co-pay accumulator programs. Co-pay assistance from drug manufacturers is frequently the only way many Americans with chronic and/or complex conditions can afford their medications, yet insurer co-pay accumulator programs prevent these payments from counting toward a patient's total out-of-pocket expenses, subjecting patients to often insurmountable out-of-pocket expenses and allowing health plans to "double dip" by accepting both the co-pay assistance and any additional cost-sharing paid by the patient before the out-of-pocket limit. Studies show that patients are more likely to skip or abandon their treatment when out-of-pocket costs increase, which can lead patients to lose control of their disease and increase visits to the emergency room, thereby increasing total costs to the health system. The AMA strongly urges CMS to address harmful co-pay accumulator programs in the final rule through actions such as requiring insurers to include co-pay assistance payments in their calculation of an enrollee's out-of-pocket limit to ensure patients have continued access to the medications they need.

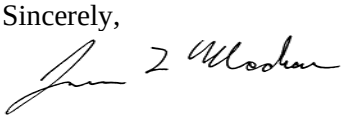
Enhancing Accuracy, Integrity, and Transparency Amongst Marketplace Plans and Issuers

The AMA supports several proposals intended to enhance the accuracy, integrity, and transparency of marketplace issuers and plans, including codifying that State Exchanges must resolve data inaccuracies within 60 calendar days, extending HHS' authority to investigate and seek compliance actions for noncompliance at an agency-level and in states operating exchanges on the federal platform, codifying that Exchanges may deny certification of plans that do not meet certification criteria, expanding HHS' authority to immediately suspend systems or agents' abilities to transact information with the Exchange if an unacceptable risk is posed, and adding a section to the model consumer consent form for documentation of consumer review and confirmation of the accuracy of their information to reduce the potential for fraudulent entries. The AMA agrees that program integrity is of paramount concern and appreciates the agency's responsiveness to consumer complaints and commitment to protecting enrollee protected health data and pursuing issuer misconduct. We encourage CMS to finalize these proposals.

We agree that HHS' proposals to increase coordination with State Departments of Insurance and the National Association of Insurance Commissioners and to utilize the "quick ratio" as a second, more conservative indicator of issuer financial stability and ability to quickly make good on its debts are potentially promising strategies to help ensure the viability of individual issuers, and in turn, stabilize the marketplace. We appreciate HHS' recognition that state insurance authorities understand nuances about their local markets and populations and its assurance that state licensing requirements would not be preempted. We agree that a collaborative approach with states is more productive than imposing federal requirements. However, more information on how both policies would be designed and how both would impact plan eligibility and offerings, particularly in regions with limited coverage offerings, should be provided. For example, would CMS deem a certain threshold for quick ratios unacceptable?

Thank you for your consideration of these comments. We look forward to continuing to strengthen and improve marketplace coverage for all Americans. To further discuss the content of this letter, please contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD