NATIONAL WOMEN'S LAW CENTER
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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9888-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted Electronically

RE: RIN 0938-AV41; CMS-9888-P
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program

The National Women's Law Center ("the Law Center") appreciates the opportunity to comment on the Notice of Benefit and Payment Parameters for 2026.[1] Since 1972, the Law Center has fought for gender justice in the courts, in public policy, and in our society. The Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and intersecting forms of discrimination. Through our work to develop and implement the Affordable Care Act (ACA), we have seen its impact on women's health and access to care. Millions of women have been able to secure health coverage and health care free from discriminatory practices because of the ACA. We firmly believe that robust enforcement of its provisions will continue to improve women's health and wellbeing.

We support many aspects of the rule and offer suggestions to strengthen it. Among other recommendations, we urge the Department of Health and Human Services ("the Department") to adopt the following:

- Require all Exchanges to provide an annual Failure-to-Reconcile (FTR) notice for each year that a consumer a fails to reconcile their Advance Premium Tax Credits (APTC);
- Adopt the proposed fixed-dollar and gross premium payment threshold options;
- Strengthen enforcement against agents, brokers, and lead agents who engage in unauthorized Marketplace activity;
- Allow assisters to refer consumers to financial programs to reduce medical debt;

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program, 89 Fed. Reg. 82308 (proposed October 10, 2024) (to be codified at 42 C.F.R pt. 600; 45 C.F.R. pts. 153,155,156, and 158) (hereinafter "Proposed Rule").

- Adopt the proposed requirement for meaningfully different standardized plan options;
- Adopt the proposed qualified health plan (QHP) certification denial and essential community provider (ECP) certification review authority;
- Adopt the proposed pre-exposure prophylaxis (PrEP) factor for risk adjustment models.

I. Mitigating Coverage Disruptions

a. Failure to Reconcile

We support the Department's proposal to require all Exchanges, including state Exchanges, to send annual Failure-to-Reconcile (FTR) notices to enrollees or tax filers, including when they have failed to file and reconcile their Advanced Premium Tax Credit (APTC) for a second consecutive year. Annual FTR notices, including second-year notices, remind enrollees or tax filers to file and reconcile as soon as possible, or to appeal any error with their FTR status, reducing the risk of unwarranted denials for the 93%[2] of enrollees receiving APTC.

A second-year notice is crucial given that some enrollees or their tax filers may not have received the first FTR notice. Address changes, particularly due to housing instability, may prevent receipt of mailed notices for the first year of failure to reconcile. This is particularly true for women and LGBTQI+ people, who are significantly more likely than men to face housing instability.[3] And other enrollees, particularly women in rural areas,[4] may have had difficulty accessing electronic messages due to inadequate internet or computer access. Further, enrollees or their tax filers may not understand, due to language or literacy barriers, that they will be immediately ineligible for APTC if they do not reconcile for a second consecutive year.

Exchanges can further reduce the risk of some of these problems by integrating the APTC notice into the enrollment process. For example, in addition to annual FTR notices, Exchanges can create an automatic popup alert that is displayed when an applicant accesses the enrollment website, alerting the enrollee of APTC responsibilities. The pop up can also provide a link to a centralized hub for FAQ's and tutorials that instruct consumers how to address APTC responsibilities and FTR notices. Exchanges can also provide a broad reminder about APTC responsibilities, regardless of whether an enrollee is in FTR status, prior to tax-filing deadlines. This information should be accessible to people with a range of disabilities and available in the most common languages spoken in the state.

We continue to urge the Department to cease denials of APTC until there is an effective and constitutionally sound procedure for notice to non-tax filers. To comply with restrictions on the

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[2] CMS, *Effectuated Enrollment: Early 2024 Snapshot and Full Year 2023 Average* (Mar. 2024), https://www.cms.gov/files/document/early-2024-and-full-year-2023-effectuated-enrollment-report.pdf.
[3] National Women's Law Center, *Housing Discrimination Still Remains a Reality for Many Women and LGBTQIA+ People* (Apr. 2024), https://nwlc.org/wp-content/uploads/2024/04/Housing-Discrimination-Still-Remains-a-Reality-for-Many-Women-and-LGBTQIA-People-Accessible-April-2024.pdf.
[4] Emma Kaufman, *Intersectionality in Depth, Part 1: Women in Rural Landscapes* (Mar. 4, 2024), https://edi.nih.gov/the-EDI-pulse-blog/intersectionality-depth-part-1-women-rural-landscapes; Emily Vogels, *Some Digital Divides Persist Between Rural, Urban and Suburban America* (Aug. 19, 2021), https://www.pewresearch.org/short-reads/2021/08/19/some-digital-divides-persist-between-rural-urban-and-suburban-america/.

release of tax information to enrollees who are not the household tax filers, the proposed rule continues to allow indirect notices for both first- and second-year notices. Many consumers already find tax notices difficult to understand due to language barriers, literacy, and disability. Indirect notices may further confuse enrollees as they do not specify the reason for potential APTC eligibility loss and are often too vague to inform individuals of their FTR status, increasing the risk of unwarranted denials of APTC. Particularly for those who have failed to file and reconcile for two consecutive years, indirect notices do not convey the immediacy of APTC eligibility loss, raising serious due process questions. The harm of an eligible consumer improperly losing APTC far outweighs any deterrent value of the APTC denial policy.

b. Premium Payment Threshold Options

We support the Department's fixed-dollar payment threshold proposal and gross premium percentage proposal. Affordability remains a concern for enrollees,[5] particularly for low-income women,[6] and enrollees may fail to pay their full premium payments due to financial hardship. Allowing fixed-dollar and gross premium payment thresholds increases the payment threshold for enrollees struggling to pay their full premium amount, and can decrease the number of consumers placed in grace periods and reduce rates of coverage termination due to failure to pay de minimis amounts.

Individuals with lower incomes are more likely to be harmed by coverage termination due to amounts under $5, or within the 99% gross premium threshold. Loss of coverage due to an unaffordable premium negatively impacts health and increases out-of-pocket health care costs and medical debt..[7] Many of those who lose coverage remain without coverage for upwards of 6 months, and some may not re-apply at all.[8] Uninsured individuals are less likely to receive preventive care and/or care for major health conditions and chronic diseases.[9] And uninsured women, disproportionately Black, Latina, and Native women, receive inadequate and low-quality care, resulting in poorer health outcomes.[10] Greater flexibility for premium payments will help enrollees maintain coverage. We support both the fixed-dollar and gross premium payment threshold options.

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[5] Luna Lopes et al., *Americans' Challenges with Health Care Costs* (Mar. 1, 2024), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.

[6] Michelle Long et al., Women's Health Care Utilization and Costs: Findings from the 2020 KFF Women's Health Survey (Apr. 21, 2021), https://www.kff.org/womens-health-policy/issue-brief/womens-health-care-utilization-and-costs-findings-from-the-2020-kff-womens-health-survey/.

[7] Madeline Guth et al., Understanding the Impact of Medicaid Premiums & Cost-Sharing (Sep. 9, 2021), https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers; Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (Jun. 1, 2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings.

[8] Liran Einav Amy Finkelstein, *The Risk of Losing Health Insurance in the United States is Large, and Remained so After the Affordable Care Act*, 18 PROC. NAT'L ACAD. SCIENCES e2222100120 (Apr. 2023), https://www.pnas.org/doi/full/10.1073/pnas.2222100120.

[9] Jennifer Tolbert, *Key Facts about the Uninsured Population* (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[10] Kaiser Family Foundation, *Women's Health Insurance Coverage* (Dec. 13, 2023), https://www.kff.org/womenshealth-policy/fact-sheet/womens-health-insurance-coverage.

However, we encourage the Department to apply the fixed-dollar and gross premium options to binder payments, particularly as the current net premium option is applied to binder payments. [11] The Department is concerned that the fixed-dollar or gross premium options, if applied to binder payments, may allow certain enrollees to effectuate coverage without making payment, and that non-payment of a binder payment would fail to signify that the coverage is desired by the enrollee. However, applying either of the new options under a binder-payment exclusion scheme would mean that a consumer that just slightly underpays a binder payment would not have effectuated coverage. We encourage the Department to consider applying the fixed-dollar and gross premium payment threshold to the binder payment, with the limitation of requiring a non-zero binder payment, in order to maintain effectuation rates and allow issuers and enrollees flexibility from the first payment.

II. Protecting Consumers

a. Enforcements against Agents and Brokers

We support the proposal to strengthen enforcement actions against agents and brokers engaging in unauthorized Marketplace activity and to apply the same enforcement authority to lead agents. To protect consumers from fraudulent behavior, it is critical to immediately impose a system suspension on agents and brokers that engage in misconduct.

While Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) websites remove barriers to enrollment and the majority of agent or broker-assisted active enrollments occur through these pathways,[12] DE/EDE websites also facilitate bad actors. Agents and brokers engaging in unauthorized plan switching may target low-income individuals eligible for "zero premium" plans. Without a monthly premium payment bill, unauthorized switches are more likely to go unnoticed or unreported, allowing agents and brokers to continue engaging in unauthorized behavior.

Agent and broker misconduct, such as unauthorized plan switching, is particularly harmful towards women, LGBTQI+ people, disabled people, and low-income individuals. An unauthorized plan may not include the same doctors or may come with higher deductibles than an individual's former coverage. This limits access to necessary care, particularly for those with greater health needs and chronic conditions—women,[13] LGBTQI+ people,[14] and disabled people.[15] Low-income individuals, disabled people, and people working multiple jobs—of which

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[11] *See* 45 C.F.R. § 155.400(g)

[12] CMS, *2023 Agent and Broker Summit* (May 24, 2023), https://www.cms.gov/files/document/ab-summit-2023-welcome-slides.pdf.

[13] Kaiser Family Foundation, *Health Policy Issues in Women's Health* (Jul. 29, 2024), https://www.kff.org/health-policy-101-health-policy-issues-in-womens-health/?entry=table-of-contents-what-is-the-demographic-profile-of-women.

[14] Manasvi Pinnamaneni et al., *Disparities in Chronic Physical Health Conditions in Sexual and Gender Minority People Using the United States Behavioral Risk Factor Surveillance System*, 28 PREVENTIVE MED. REP. 101881 (Mar 27, 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC9287429/.

[15] Monika Mitra, *Advancing Health Equity and Reducing Health Disparities For People With Disabilities In The United States*, 41 HEALTH AFFAIRS (Oct. 2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00499.

women comprise a greater share,[16] may also have limited capacity to file complaints. Barriers related to language and literacy further impede victims of unauthorized plan-switching from re-instating their original insurance plan.

Federal enforcement actions on lead agents can incentivize agents and brokers within the same entity to comply with Exchange standards. And immediate system suspensions against agents and brokers who engage in misconduct can limit harms against all consumers on the Marketplace.

b. Reducing Medical Debt

We support allowing assisters and Certified Application Counselors (CACs) to connect consumers to financial assistance programs to help reduce medical debt. Assisters and CACs are well-positioned to connect consumers to financial assistance programs.

Over 41% of working-age Americans struggle with medical debt,[17] with women and people of color more likely to be burdened by medical debt.[18] It is devastating for consumers, contributes to financial distress and greater health care needs, and directly impacts health care coverage affordability.[19] Under § 155.210(e)(9), assisters are charged with providing targeted assistance to serve underserved or vulnerable populations, as identified by the Exchange. We encourage Exchanges to identify individuals with medical debt as a vulnerable population[20] and/or to expand § 155.210(e)(9) to allow assisters to refer consumers to state or federal financial assistance programs to reduce medical debt.

III. Improving Coverage Quality

a. Multiple Standards Plans

We support the Department's proposal to require issuers that offer multiple standardized plan options within the same product network type, metal level, and service area, to ensure that there is a meaningful difference among the standardized plans in terms of benefits, provider networks, and formularies. Issuers offering standardized plan options that are nearly identical confuses

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[16] Keith A. Bailey & James R. Spletzer, A New Way to Measure How Many Americans Work More Than One Job (Feb. 3, 2021), https://www.census.gov/library/stories/2021/02/new-way-to-measure-how-many-americans-work-more-than-one-job.html.

[17] Shameek Rakshit et al., *The Burden of Medical Debt in the United States* (Feb. 12, 2024), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states.

[18] *Id.;* Miranda Santillo et al,, *Communities of Color Disproportionally Suffer from Medical Debt* (Oct. 14, 2022), https://www.urban.org/urban-wire/communities-color-disproportionally-suffer-medical-debt.

[19] Sara Collins et al., *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer* (Oct. 26, 2023), https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey.

[20] Those with medical debt are much more likely to have indicators of financial vulnerability. Aubrey Winger et al., *How Financially Vulnerable are People with Medical Debt?* (Feb. 14, 2022), https://www.healthsystemtracker.org/brief/how-financially-vulnerable-are-people-with-medical-debt/.

consumers. The resulting choice overload makes it harder for consumers to select the plan that best aligns with their needs and it deters some from choosing a plan at all.[21]

Studies suggest that women, older adults, people with chronic health conditions, and people with low incomes, are particularly harmed by choice overload in health insurance. When presented with a large number of options, these groups may be more likely to make enrollment decisions that result in higher than optimal costs.[22] Additionally, variations often cannot be identified without a detailed analysis of benefit designs and may create barriers for people who already have constrained resources for navigating insurance—such as people with limited English proficiency,[23] low incomes, complex health needs, or inadequate internet access.[24]

We support the Department's proposal to require meaningful differences to reduce choice overload. We further recommend that issuers depict meaningful differences with text, relevant graphics, and other tools that aid in understanding for a range of disabilities. Ensuring that differences between standardized plans within the same network type, metal, or service area can be readily understood will benefit people who face barriers to health literacy or who have complex health needs.

b. QHP Certification and ECP Reviews

We support the Department's proposal to clarify that an Exchange has authority to deny certification of plans that do not meet QHP criteria. QHP certifications assist consumers in identifying plans that may be most responsive to their health needs, such as whether a plan is compliant with essential community provider (ECP) requirements within the network.[25] Similarly, we support the Department's proposal to conduct independent ECP certification reviews of plans for which issuers submit QHP certification applications in Federally Facilitated Exchanges (FFEs) in states performing plan management functions. Independent federal review of ECP data from states that perform plan management functions will strengthen the integrity of ECP and QHP certifications across all FFEs, ensuring compliance with ECP standards.

ECPs provide vital care to predominantly low-income and medically underserved communities, including women, people of color, LGBTQ+ people, and disabled people. Many women rely on ECPs like family planning clinics for sexual and reproductive health, preventive health screenings, and other care. And Ryan White clinics are critical for people living with HIV, who

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[21] See Rose C. Chu et al., Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces 3 (Dec. 28, 2021), https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.
[22] Saurabh Bhargava et al., *Do Individuals Make Sensible Health Insurance Decisions? Evidence From a Menu With Dominated Options* (May 2015), https://www.nber.org/system/files/working_papers/w21160/w21160.pdf.
[23] Tianyi Lu & Rebecca Myerson, *Disparities in Health Insurance Coverage and Access to Care by English Language Proficiency in the USA, 2006–2016*, 35 J. GENERAL INTERNAL MED. 1490 (2020), https://doi.org/10.1007/s11606-019-05609-z.
[24] *See, e.g.*, Krutika Amin et al., *How Might Internet Connectivity Affect Health Care Access?* (2020), https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access.
[25] *See* 45 C.F.R. § 156.235

are disproportionately LGBTQI+ people and people of color, and who have historically faced stigma and discrimination in other health care settings.

The explicit authority to deny QHP certification to plans and issuers that do not meet certification requirements, along with independent federal review of ECP certifications, can improve coverage quality and selection. These proposals help ensure that consumers can reliably select appropriate plans and that all enrollees under QHP certified plans, particularly women, women of color, and LGBTQ+ people, have adequate access to necessary ECPs.

c. Inclusion of Pre-Exposure Prophylaxis in Risk Adjustment

The Department requests input regarding the addition of a new category of risk adjustment factors, Affiliated Cost Factors (ACFs), for the receipt of PrEP. We appreciate the Department's commitment to improving the risk adjustment model to help offset costs and prevent adverse selection. We support the creation of a risk adjustment factor for PrEP receipt, which disincentivizes issuers from introducing barriers, such as prior authorization, and passing the costs of PrEP associated services to enrollees.[26] This will help ensure that people living with HIV, who are disproportionately LGBTQI+ people and people of color,[27] will have access to the full range of health care options and to PrEP, associated lab tests, and other related services.

VI. Conclusion

We appreciate the opportunity to comment on this proposed rule. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further information, please contact Airin Chen, Ann Kolker Fellow for Health Equity and Justice at the National Women's Law Center, at ayungchen@nwlc.org.

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[26] Sarah Varney, *HIV Preventive Care Is Supposed to Be Free in the US. So, Why Are Some Patients Still Paying?* (Mar. 3, 2022), https://kffhealthnews.org/news/article/prep-hiv-prevention-costs-covered-problems-insurance/

[27] Kaiser Family Foundation, *The Impact of HIV on Hispanic/Latino People in the United States* (Oct. 15, 2024), https://www.kff.org/hivaids/fact-sheet/the-impact-of-hiv-on-hispanic-latino-people-in-the-united-states/; Kaiser Family Foundation, *The Impact of HIV on Black People in the United States* (Sep. 9, 2024), https://www.kff.org/hivaids/fact-sheet/the-impact-of-hiv-on-black-people-in-the-united-states; CDC, *Fast Facts: HIV and Transgender People* (Mar. 28, 2024), https://www.cdc.gov/hiv/data-research/facts-stats/transgender-people.html.