November 12, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-9688-P– Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2026
89 Fed. Reg. 82308 (October 10, 2024)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters (NBPP) for plan year 2026. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

More than 2 million Americans will be diagnosed with cancer this year and more than 18 million Americans living today have a history of cancer.[1] For these individuals, finding the right doctor is a vital factor in their treatment and directly affects the affordability of their care. In general, we support many of the proposals contained in the 2026 NBPP proposed rule and offer comments on the following:

- *Navigator, Standards and Other Related Standards*
- *Reducing the Risk that Issuer Insolvencies Pose to the Integrity of FFEs*
- *FFE and SBE-FP User Fee Rates for the 2026 Benefit Year*
- *Standardized Plan Options*
- *Essential Community Provider Reviews for States Performing Plan Management*

Copay Accumulator Policy*:* We are very concerned that HHS did not take this rulemaking opportunity to rescind the 2021 policy allowing issuers to not count manufacturer coupons towards an individual's limitation on cost-sharing. This policy creates financial barriers for cancer patients and survivors seeking access to essential therapies. ACS CAN supports the use of copay assistance programs because many individuals would otherwise not be able to afford the cost sharing associated with their physician-prescribed drugs – particularly new and innovative therapies.

According to an ACS CAN Survivor Views survey, 31% of cancer patients and survivors find I difficult to afford their prescription drug costs.[2] Among patients with annual household income below $35,000, 45% find

[1] American Cancer Society. *Cancer Facts & Figures 2024.* Atlanta: American Cancer Society; 2024.
[2] ACS CAN Survivor Views: Copay Assistance and Patient Navigation. Fielded May 16-26, 2022 (n=1,241). Available from Survivor Views: Copay Assistance and Patient Navigation | American Cancer Society Cancer Action Network (fightcancer.org).

prescription drug costs difficult and one-in-five say it is very difficult to afford them. One-fifth report having skipped or delayed taking a prescribed medication due to difficulty paying the cost, with significantly higher rates of missed medication reported by lower income (44%), Asian/Pacific Islander (40%), Black (44%), and Hispanic (58%) patients and survivors. Among cancer patients and survivors who have enrolled in copay assistance programs, the benefits are clear. Eighty-five percent agree that the assistance they receive provides significant savings, making their prescription drug costs much more affordable, while 83% say it helps them access medication they otherwise could not afford, and allows them the take their medication as prescribed.

In HIV and Hepatitis Policy Institute v. HHS, a federal district court set aside the 2021 Notice of Benefit and Payment Parameters rule with respect to copay accumulator programs.[3] As part of that litigation, HHS noted that it "intend[s] to address, through rulemaking … whether financial assistance provided to patients by drug manufacturers qualifies as 'cost sharing' under the Affordable Care Act."[4] However, HHS failed to use the plan year 2026 NBPP rulemaking process as an opportunity to address this issue, choosing instead to address the issue in future rulemaking.[5]

Consistent with this litigation, we urge HHS to swiftly undergo formal rulemaking to formally rescind the policy adopted in the 2021 NBPP rulemaking and reinstate the policy finalized in the 2020 NBPP rulemaking which would require issuers to include any amounts paid toward an enrollee's cost-sharing when calculating the enrollee's annual limitation on cost-sharing.

III. Provisions of Proposed HHS Notice of Benefit and Payment Parameters for 2024

C. Part 155 – Exchange Establishment Standards and Other Related Standards

1. Solicitation of Comments – Navigator, Standards and Other Related Standards

CMS is soliciting comments regarding how assisters who perform their assister duties in a hospital setting may refer consumers to programs designed to reduce medical debt.

ACS CAN commends HHS for its proposal to empower Certified Application Counselors (CACs) and non-Navigator consumer assisters, particularly those in hospitals and health systems, to refer patients to medical debt relief programs. As trusted members of their communities, consumer assisters are uniquely positioned to provide helpful, accessible guidance to those facing complex financial and healthcare decisions. This step is vital to reducing financial burdens on vulnerable populations—including young adults, veterans, low-income individuals, and communities of color—who disproportionately experience medical debt.

Consumer assisters already help individuals enroll in Marketplace coverage and have the expertise to guide patients through debt relief options, providing clear explanations of eligibility and processes. For cancer patients, this support is especially critical; a recent 2024 Survivor Views survey[6] found over half incur medical debt, leading many to delay necessary treatments, increasing their risk of poor outcomes.

However, ACS CAN urges HHS to ensure that this initiative complements, rather than replaces, hospitals' existing

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[3] HIV and Hepatitis Policy Institute v. HHS, Civ. A. No. 1:22-cv-2604 (JDB), 2023 WL 6388932 (D.D.C. Sept. 29, 2023).
[4] Defendant's Conditional Motion to Clarify Scope of Court's Order at 2, HIV and Hepatitis Policy Institute v. HHS, Civ. A. No. 1:22-cv-2604 (JDB).
[5] 89 Fed Reg. 82308 ("*Intention of Future Rulemaking*: HHS and the Departments of Labor and Treasury intend to issue a future notice of proposed rulemaking address the issues arising out of HIV and Hepatitis Policy Institute et al. v. U.S. Department of Health and Human Services et al., Civil Action No. 22–2604 (D.D.C. Sept. 29, 2023), namely, the applicability of drug manufacturer support to the annual limitation on cost sharing.).
[6] American Cancer Society Cancer Action Network, *Survivor Views Survey* fielded March 18-April 14 (1,248n) available from https://www.fightcancer.org/sites/default/files/national_documents/sv_debt_summary_24.pdf.

charity care obligations. Hospitals must continue to fulfill their financial assistance duties, with consumer assisters acting as an additional layer of support to help patients manage their medical debt and access the care they need.

D. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Solicitation of Comments – Reducing the Risk that Issuer Insolvencies Pose to the Integrity of FFEs

HHS outlines instances where issuer insolvencies have disrupted markets, including the Exchanges. HHS is seeking input on ways to reduce the risk that these financial failures posed to federally facilitated marketplaces (FFEs).

ACS CAN appreciates HHS' efforts to minimize issuer insolvencies in FFEs. Insolvencies not only negatively impact the stability of the overall FFE, but can have devastating impacts on consumers who are enrolled in plans that become insolvent. While we appreciate that enrollees whose plan becomes insolvent are granted a special enrollment period (SEP) in which to enroll in a new plan, as is often the case, the new plan will have a different plan network and formulary, which may not match the needs of the enrollee. This places an added burden on impacted enrollees who then have to file appeals (with no guarantee of a successful outcome) with their new plan. This could lead to disruptions in care and access to medically appropriate products and services. We therefore urge HHS to develop stringent financial requirements on all issuers operating in the FFEs to ensure they are appropriately capitalized throughout the plan year to avoid any mid-year insolvencies.

2. FFE and SBE-FP User Fee Rates for the 2026 Benefit Year (§ 156.50)

HHS is proposing a FFE user fee rate of 2.5% of total monthly premiums and a state-based exchange-FP (SBE-FP) user fee rate of 2.0% of monthly premiums. User fees are paid by Marketplace issuers to support the operations such as eligibility and enrollment processes, education and outreach, and oversight of Marketplace plans. HHS justifies these user fees as being necessary if Congress fails to act to extend the enhanced ACA tax credits which are due to expire at the end of December 2025. If Congress extends the enhanced ACA tax credits through plan year 2026, HHS proposes reducing user fee rates to between 1.8%-2.2% for FFEs and 1.4-1.8% for SBE-FPs.

ACS CAN appreciates that HHS is making plans to attempt to mitigate the disaster that could occur if Congress fails to extend the enhanced ACA tax credits. ACS CAN is urging Congress to make the ACA enhanced tax credits at their current levels permanent before they expire in 2025. These enhanced tax credits led to record enrollment in Marketplace plans and have provided millions with a path to affordable, comprehensive coverage to be able to prevent, detect and treat cancer. If the enhanced tax credits are not made permanent, affordability could become a barrier to lifesaving cancer screening, early detection, treatment and follow up care.

6. Standardized Plan Options (156.201)

HHS proposes to maintain the standardized plan options first introduced in 2017, and later expanded in the 2024 Payment Notice. HHS proposes to require that issuers meaningfully differentiate between standard plan options with respect to benefits, provider networks, formularies, or any combination thereof.

ACS CAN continues to support the continuation of standard plan offerings, which help consumers better compare plan options. We strongly support HHS' proposal to ensure that issuers meaningfully differentiate between plan options. While having a choice of health plans is an important consumer protection, having too many options – particularly options offered by the same issuer in which there is minimal variation in benefit design – can be confusing for consumers. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS), which provides cancer patients with information about health insurance options that

may be available to them in their area. HIAS representatives often hear from individuals with cancer about how overwhelming it can be to make insurance enrollment decisions while also dealing with cancer. It is crucial that individuals with cancer and survivors are able to choose a health insurance plan that provides coverage for their unique needs.

8. Essential Community Provider Reviews for States Performing Plan Management (156.235)

HHS proposes that beginning with the certification reviews for plan year 2026 it will conduct federal essential community provider (ECP) certification reviews of plans for which WHP certification applications are submitted in FFEs with states that perform plan management functions. As a result, issuers applying for certification of plans as QHPs in any FFE would be evaluated against consistent requirements and standards, thus improving the oversight of ECP data across all FFEs.

ACS CAN supports this approach. Strong ECP in-network requirements are a critical step towards improving access to care, especially given that ECPs serve as an entry point into the broader healthcare system and an ongoing source of care for millions of families.

However, we urge HHS to modify the ECP standards in future rulemaking so that cancer patients have better access to specialized facilities. Currently, cancer hospitals and children's hospitals (which are primary providers of pediatric oncology services) are included within the broader ECP hospital category. As a result, these specialized facilities are often not in a QHP's network which impedes an enrollee's access.

CONCLUSION

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for plan year 2026. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network