Charles N. Kahn III
President and CEO

November 12, 2024

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

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026 [CMS–9888–P]

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule on the *HHS Notice of Benefit and Payment Parameters for 2026* (Proposed Rule) published in the Federal Register (89 *Fed. Reg.* 82,308) on October 10, 2024.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (Part III.C.1)

The Proposed Rule solicits comments with respect to the role that Navigators and other assisters may play with respect to connecting consumers to financial assistance programs within hospitals, hospital systems, and their communities. The FAH strongly supports the work that Navigators, Non-Navigator Assistance Personnel, and Certified Application Counselors do in

working with consumers to access health care coverage, and is concerned that the proposed expansion of their role to refer consumers to programs designed to reduce medical debt would distract from the critical role they play at the time of enrollment—a role that has enormous potential to improve consumers' access to affordable care and reduce the risk of medical debt through adequate and appropriate coverage.

Assisters collectively play a critical role in helping consumers to apply for and enroll in coverage through the Exchanges, and in fulfilling this role, they provide information about the cost-sharing obligations, including those for a high-deductible plan, under available qualified health plan (QHP) options and insurance as well as insurance affordability programs. Because the assister's interaction with the consumer is at the point of acquiring coverage, they are best suited to help consumers prospectively mitigate the risk of medical debt by identifying plans and insurance affordability programs that provide affordable access to care and educating about options that involve excessive and unsustainable cost-sharing obligations. Overall, medical debt is a symptom of inadequate coverage and excessive cost-sharing obligations placed on consumers, and the FAH urges HHS to explore assister requirements or guidance that ensure assisters take this critical opportunity to minimize consumers' risk of medical debt. Such measures would appropriately dovetail with the core coverage-oriented expertise and competency of assisters rather than diverting their attention to other problems that require the expertise of others (*e.g.*, financial counselors).

With respect to HHS's statutory authority, the FAH does not believe that Congress delegated HHS authority to require assisters to play a role disconnected with the Exchange's core functions as a marketplace for health care coverage and a gateway for coverage. Consistent with this statutory focus, existing regulations require Exchanges to establish Certified Application Counselor programs that provide information to consumers about the full range of QHP options and insurance affordability programs, help consumers make informed decisions during the health care coverage selection process, assist consumers in applying for coverage and insurance affordability programs, and help facilitate enrollment in such coverage and programs. In this way, the role of Certified Application Counselors is directly related to the operation of the Exchanges such that the requirements are within HHS's authority under section 1321(a)(1) of the ACA. But an expanded role that requires Certified Application Counselor to provide information on financial assistance programs is disconnected from coverage assistance and the statutory Exchange functions altogether. Therefore, the FAH urges HHS to instead maximize assisters' roles in preventing or minimizing medical debt by promoting informed coverage decisions and allow others with appropriate expertise to provide financial counseling.

Model Consent Form and Assistance by Agents, Brokers, and Web-Brokers (Part III.C.2)

The FAH supports the continuing efforts of HHS to ensure the accuracy of Exchange enrollee eligibility and the use of a Model Consent Form as proposed. The Model Consent Form is a useful tool to verify that enrollees in Exchange plans have consented to the plan and coverage they intended and to confirm Exchange eligibility information. The use of this documentation will protect consumers, patients and their brokers, agents, and providers in the event of a dispute as to the plan terms and coverage selected.

Optional Fixed-Dollar Premium Payment Threshold and Total Premium Threshold (Part III.C.5)

The FAH supports providing issuers with flexibility to set reasonable premium payment thresholds that may be fixed-dollar thresholds, net premium percentage thresholds, or gross premium percentage thresholds, with the aim of minimizing situations where a grace period is triggered, or coverage is terminated as a consequence for nonpayment of limited dollar amounts. Under the current regulation, the threshold must be based on the percentage of total premium paid of the total premium owed by the consumer (*i.e.*, a net premium percentage threshold), must be at a reasonable level, and must be applied in a uniform manner. Because many consumers receive significant advance payment of the premium tax credits, a net premium percentage threshold—particularly one that is set at or above 95% as per CMS's recommendation—may still result in the triggering of the grace period or termination based on a *de minimum* unpaid premium amount. A fixed-dollar premium payment threshold policy, in contrast, would look to the outstanding dollar amount owed by the consumer, which could be a high percentage of the total monthly premium payment owed by the consumer but a low dollar amount. And a gross premium payment threshold would be based on the percentage of total premium payments owed by the consumer, which would appropriately account for the advance payment of the consumer's premium tax credit.

The FAH, however, recommends that HHS consider maintaining the current structure of 42 C.F.R. § 155.400(g), which codifies the requirement that the threshold be reasonable and uniformly applied without codifying any specific limit on reasonableness. Some issuers may have current policies that apply a net premium payment threshold of less than CMS's current recommendation of 95 percent, and the Proposed Rule does not assess the impacts of codifying the current recommendation (along with codifying a fixed-dollar threshold requirement of $5 or less and a gross premium percentage threshold of 99% or more). Nor does the Proposed Rule indicate that the current reasonableness standard is problematic or would not be appropriate in the context of a fixed-dollar threshold or gross premium payment threshold.

The FAH also believes that it would be appropriate for an issuer to adopt a premium payment threshold policy that applies a greater-of methodology whereby a consumer whose outstanding premiums fall below the greater of the three possible thresholds would be subject to that threshold. For example, if a consumer selected a QHP with a total monthly premium amount of $300 and receives $299 in advance premium tax credits, the greater-of methodology would produce a threshold of $5 (the fixed-dollar threshold), which is greater than the net premium threshold (5% of $1 or $0.05) or the gross premium threshold (1% of $300 or $3). But for another consumer with a higher monthly premium, the gross premium payment threshold might result in a higher threshold. The FAH supports the flexibility to adopt a greater-of methodology and requests that CMS confirm that such a methodology would satisfy the uniformity requirement under 42 C.F.R. § 155.400(g).

Lastly, in the aftermath of the Supreme Court decision in *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (2024), the FAH urges HHS to re-evaluate its grace period regulations and amend them consistent with the ACA's statutory language. The ACA provides for a "3-month grace period for non-payment of premiums before discontinuing coverage" for individuals receiving advance payment of the premium tax credits. ACA § 1412(c)(2)(B)(iv)(II) (42 U.S.C. § 18082(c)(2)(B)(iv)(II)). The ACA also broadly prohibits rescissions, permitting

cancellation for non-payment only with prior notice to the enrollee. Public Health Services Act § 2712 (42 U.S.C. § 300gg-12). When adopting grace period regulations, HHS initially proposed that Exchange insurers would pay all appropriate claims during the grace period, consistent with the plain text of the statute. But the final regulation instead adopted a policy where claims can be pended for the second and third month of the grace period and then coverage terminated retroactive to the first day of the second month of the grace period. 77 Fed. Reg. 18,310, 18,426 – 29 (Mar. 27, 2012); *see* 42 C.F.R. §§ 155.430(d)(4), 156.270(g). This policy places providers that furnish services to QHP enrollees that receive advance payment of the premium tax credit at risk and also fails to provide the grace period coverage mandated by the ACA. In the aftermath of *Loper Bright*, HHS's interpretation of the ACA's grace period requirements is not entitled to deference under *Chevron*, and the FAH urges HHS to return to the statutory grace period language that protects both consumers and the providers that care for them during the entirety of the 3-month grace period.

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Thank you for the opportunity to comment on the Proposed Rule. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,