



January 30, 2023

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

Re: CMS-9899-P, ACA Proposed Notice of Benefit and Payment Parameters for 2024

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to submit comments on the Proposed Notice of Benefit and Payment Parameters for 2024. We are supportive of the proposals set forth in the Notice and applaud the continued efforts of CMS to expand access to, and enrollment in, quality, affordable, health insurance coverage—especially for the more than 5 million Americans aged 50-64 who get their coverage through an exchange.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Program Standards

AARP has long supported efforts by CMS to improve and expand opportunities for enrollment in health insurance coverage. Navigators and assisters have provided nonbiased, local in-person assistance across the country to help consumers navigate, shop, and enroll in health insurance coverage through an exchange marketplace. In addition, these groups and individuals play a vital role in helping consumers prepare electronic and paper applications to establish eligibility, complete enrollment documentation, and potentially qualify for premium financial assistance (APTCs) or out-of-pocket cost assistance (CSRs).

We support the proposals to require agents, brokers, or web-brokers assisting with enrollment and/or financial assistance applications through the federal or state/federal partner marketplace to document that application information has been reviewed and confirmed to be accurate by the consumer prior to submission. As noted in the proposal, incorrect consumer information that is submitted by an agent or broker and not verified can result in consumers receiving inaccurate eligibility determinations and can adversely impact their tax liability. While the rule proposes that this information be retained by agents and brokers for no less than 10 years and be produced upon request by CMS, we recommend that CMS consider random, periodic audits on a regular basis. This would enable CMS to more proactively provide oversight of this process and address any obstacles that may remain to ensure accurate enrollment information.

Special Enrollment Periods

Special enrollment periods (SEPs) are important because they provide consumers with protection from gaps in coverage by allowing them to enroll when they experience major life changes outside of open enrollment periods. This proposed rule continues previous efforts to expand the availability of SEPs and improve access to health insurance coverage when it is needed.

We are supportive of the proposals meant to further remove barriers to coverage due to life events. The proposal clarifies that only one person in a household (including a dependent) would need to qualify for a SEP in order for the entire family to qualify and expands the window of notification of a life event (and therefore eligibility for a SEP) from 60 days to 90 days. These changes will help to ensure that families will not have to face additional hurdles in maintaining coverage during potentially traumatic life events and remove yet another barrier to ensuring access to quality, affordable coverage. We likewise support the proposal to permit insurance marketplaces to allow consumers up to 90 days after loss of Medicaid or CHIP coverage to select a marketplace plan and to offer earlier effective start dates. This will help create a smoother transition between insurance affordability programs and minimize potential coverage gaps, especially important with the upcoming unwinding of the public health emergency and Medicaid eligibility redeterminations.

Standardized Plans

We are encouraged by CMS's commitment to standardized plan options and proposals to refine the proposal we supported last year requiring all insurance carriers that offer Qualified Health Plans (QHPs) through exchange marketplaces to also offer standardized options. Standardized options enhance enrollee experience, increase understanding of plan options, simplify the plan selection process, combat discriminatory plan designs, and advance health equity.

AARP supports a well-balanced formulary design that enhances quality, conserves resources, and ensures consumer access to the prescription drugs they need. If CMS considers adding tiers to the formulary design for standardized plans in the future, we recommend first considering the impact that additional tiers, including associated cost sharing, would have on access and affordability for adults ages 50 to 64 enrolled in these plans.

In addition, with respect to formulary tiers, AARP has long been concerned by mixed tier composition. When plans put generic drugs on brand tiers and brand drugs on generic tiers, it can make it extremely challenging for consumers to understand their drug formulary. AARP strongly urges CMS to monitor tier composition for standardized plans to ensure that enrollees are not paying prohibitively high cost-sharing for expensive covered drugs and that tier labels are as accurate as possible. We also encourage CMS to continue exploring ways to improve affordability and make the overall enrollment process more manageable by considering ways to limit the overall number of QHPs offered in any given exchange marketplace.

Stand-Alone Dental Plans

AARP supports proposals meant to improve consumer understanding of, and access to, stand-alone dental plans. The proposal to streamline the use of age in determining a stand-alone dental plans' rate by insurance carriers will help eliminate unnecessary complexity for both consumers and the Navigators and assisters who help them.

We also support the proposal to, beginning in plan year 2024, require insurance carriers offering stand-alone dental plans to submit guaranteed plan rates for approval to respective state Departments of Insurance prior to sale on an insurance marketplace. This will eliminate the practice of providing estimated rates to consumers that typically require the enrollee to contact the insurance carrier directly to determine a final rate. As with the previous proposal, this will ensure that consumers and those who assist them will better understand their coverage and the actual premium costs they will incur.

Essential Community Providers

Essential community providers (ECPs) are critical resources of health care to predominantly underserved populations. They include such services as Indian Health Services, Federally Qualified Health Centers (FQHCs) and Ryan White AIDS providers. Under the ACA, plans are required to have enough ECPs— 35 percent of available ECP's in each plan's service area — within their provider networks. AARP is supportive of the proposal to establish two new ECP categories to better serve the needs of enrollees: Mental Health Facilities and Substance Use Disorder (SUD) treatment centers. We believe that the inclusion of these provider facilities moves us closer to the shared goal of removing barriers to accessing quality health care, especially for older Americans.

Once again, we appreciate the opportunity to share our comments on the proposed rule. If you have any questions, please do not hesitate to contact me, or have your staff contact Brendan Rose on our Government Affairs Team at 202-434-3770 or brose@aarp.org.

Sincerely,



David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs