Improving access.
Transforming health.

November 7, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure,

On behalf of The Patient Access Network (PAN) Foundation, one of the nation's largest charities, I write to provide comments on the Department of Health and Human Services' (HHS) 2026 Notice of Benefit and Payment Parameters (NBPP) proposed rule. We laud the Biden administration for making progress to increase access to health care and coverage, but more is needed to ensure that people living with a chronic illness are able to get the ongoing care they need.

PAN is an independent, national 501(c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic, and rare diseases with the out-of-pocket (OOP) costs for their prescribed medications. PAN provides patients with direct assistance through more than 70 disease-specific programs and collaborates with national patient advocacy organizations to provide patients with education and additional support. Since 2004, we have helped more than 1 million underinsured patients.

Reduce Maximum Out-of-pocket Limit

For 2026, the annual limitation on cost-sharing for Affordable Care Act (ACA) plans is more than $10,000, an amount that most patients simply do not have.[1] The ACA's annual maximum out-of-pocket limit is intended to provide financial protection to plan enrollees, however at a price point this high, it becomes meaningless for most Americans. While healthcare costs are rising, paychecks are not; the maximum out-of-pocket limit is increasing faster than wages and salaries with the divide predicted to grow year-over-year.[2] People are having to spend more of

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Consumer Information and Insurance Oversight, Final 2026 Actuarial Value Calculator Methodology, October 16, 2024. https://www.cms.gov/files/document/final-2026-av-calculator-methodology.pdf.

[2] Mathew Rae, Krutika Amin, Cynthia Cox, ACA's Maximum Out-of-Pocket Limit is Growing Faster than Wages, Peterson-KFF, Health System Tracker, July 20, 2022, https://www.healthsystemtracker.org/brief/aca-maximum-

their income on out-of-pocket health care costs. Increasing the annual threshold to over $10,000 will push more people into poorer health and debt.

When comparing the changes over time for the maximum out-of-pocket limit of ACA plans and employer-based Health Savings Account-qualified health plans, the former is increasing more rapidly than the latter due to differences in the methodology.[3] HHS could choose various policy options to slow the growth and reduce the impact on patients: the methodology and index used to set the ACA limit could be updated to mirror that of HSA plans, the benchmark used to set cost-sharing reductions could be changed from silver to gold plans, or a more reasonable cap could be instituted like in Medicare plans.[4], [5] This could alleviate the burden of out-of-pocket costs on many Americans, especially those with serious, chronic conditions.

Copay Accumulator Policy

PAN strongly supports the revision to § 156.122 instituted last year that requires plans to count all prescription drugs as Essential Health Benefits (EHB) for cost-sharing purposes. This ensures that cost sharing protections apply to the whole spectrum of a plan's drug formulary, rather than being limited to those medications the plan is required to provide. Many issuers across the country have tried to exclude some drugs from the EHB cost-sharing protections, imposing exorbitant financial burdens on consumers. As expected, the heaviest burden falls on individuals with complex health needs who use costly prescription drugs. Enforcing this policy is essential to protect these patients and strengthen health equity regarding access to prescription drugs. Importantly this requirement established that any prescription drug covered by a plan must be considered an EHB and therefore, copay accumulator programs are not allowed.

Copay accumulators are discriminatory toward those with chronic illnesses and harm patients while benefiting insurers and PBMs. Copay accumulator adjustment policies unfairly target people with serious, chronic illness, undermining the Affordable Care Act (ACA) protections that prohibit insurers from charging people with pre-existing conditions more for health insurance than healthier enrollees. Copay assistance is available generally for high-cost brand and specialty medications without a medically equivalent generic alternative and is used by people

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out-of-pocket-limit-is-growing-faster-than-wages/#Maximum%20out-of-pocket%20limits%20for%20HSA-qualified%20health%20plans%20and%20other%20private%20non-grandfathered%20health%20plans,%20actual%20(2014-2023)%20and%20projected%20(2024-2033).

[3] Peterson-KFF Health Systems Tracker, ACA's Maximum Out-of-Pocket Limit is Growing Faster than Wages.

[4] Center on Budget and Policy Priorities, Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges, April 10, 2024, https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees.

[5] Jesse Baumgartner, Munira Gunja, Sara Collins, The New Gold Standard: How Changing the Marketplace Coverage Benchmark Could Impact Affordability, The Commonwealth Fund, September 22 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/new-gold-standard-changing-marketplace-coverage-benchmark-affordability#:~:text=What%20Are%20Cost%2DSharing%20Reductions,percent%20AV%20(silver%2D73).

with serious and complex chronic illnesses.[6] These policies subvert the benefit of copay assistance, thereby discriminating against people living with chronic conditions. People with low incomes and people of color are more likely to be living with a chronic illness;[7] therefore, these policies target the most vulnerable patients, enabling insurance issuers to essentially underwrite insurance policies for people who require specialty or brand medications.

When copay assistance is not counted toward a patient's deductible and out-of-pocket costs, the patient alone is left responsible for paying what is often an exorbitant amount in out-of-pocket costs that can inhibit access to a needed prescription medication. This means that the insurer is often accepting payments above and beyond the maximum cost sharing requirement required by the ACA, as the dollars from third-party payments are not counted towards the calculation of the patient's deductible or annual out-of-pocket maximum. PBMs are potentially collecting the payments twice - once via copay assistance, and again when the patient requires other care, or when their copay assistance runs out and they need to get their prescriptions refilled assuming they can afford to do so.

HHS Authority and Applicability of § 156.122 to Large Group and Self-Insured Plans

The 2025 and 2026 NBPP stated that HHS and the Departments of Labor and the Treasury intend to propose rulemaking that would align the standards applicable to large group market health plans and self-insured group health plans with those applicable to individual and small group market plans, so that all group health plans and health insurance coverage subject to sections 2711 and 2707(b) of the PHS Act, as applicable, would be required to treat prescription drugs covered by the plan or coverage in excess of the applicable EHB-benchmark plan as EHB for purposes of the prohibition of lifetime and annual limits and the annual limitation on cost sharing, which would further strengthen the consumer protections in the ACA. PAN urges HHS and the Departments of Labor and the Treasury to issue such a proposed rule as soon as possible to broaden the applicability and potential benefit to more patients who are struggling to pay for their needed medications.

In summary, PAN strongly urge CMS to lower the maximum out-of-pocket limit and require insurers and PBMs to include copay assistance payments in their calculation of an enrollee's out-of-pocket limit will provide our most vulnerable with the protections they need. Additionally, CMS must prohibit the harmful strategies by plans of designating certain drugs as non-essential health benefits and then collecting the copay assistance from drug manufacturers and the growing practice of alternative funding programs. Keeping medications out of the reach of patients who need them is not good or effective policy.

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[6] K. Van Nuys, G. Joyce, R. Ribero, D.P. Goldman, A Perspective on Prescription Drug Copayment Coupons. Leonard D Schaeffer Center for Health Policy & Economics. (February 2018), https://healthpolicy.usc.edu/research/prescription-drug-copayment-coupon-landscape/

[7] The Center for American Progress, Fact Sheet: *Health Disparities by Race and Ethnicity*. (May 7, 2020), https://www.americanprogress.org/article/health-disparities-race-ethnicity/

The PAN Foundation appreciates your leadership to increase equitable access to and affordability of health care for more Americans. Thank you for your consideration of our comments. If you have questions about the issues raised, please contact Amy Niles, Chief Advocacy and Engagement Officer at aniles@panfoundation.org.

Sincerely,

Kevin L. Hagan
President and Chief Executive Officer

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