January 8, 2024

Submitted electronically via regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9895-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Notice of Benefit and Payment Parameters for 2025 Proposed Rule (CMS-9895-P)

Dear Sir or Madam,

I write on behalf of the American Benefits Council ("the Council") in connection with the Notice of Benefit and Payment Parameters for 2025 Proposed Rule (the "NBPP 2025" or "proposed rule"), issued by the U.S. departments of Health and Human Services and Treasury (the "departments").

The Council is a Washington, D.C.-based employee benefits public policy organization. The Council advocates for employers dedicated to the achievement of best-in-class solutions that protect and encourage the health and financial wellbeing of their workers, retirees and families. Council members include more than 220 of the world's largest corporations and collectively either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

To begin, we note that our members dedicate significant resources, time and effort to provide high-quality, affordable health care coverage for the more than 179 million Americans with employer-sponsored health plans. As such, our members have continuously strived to satisfy the requirements implemented by the Affordable Care Act (ACA), including by applying member cost sharing for essential health benefits (EHBs) to the annual maximum out-of-pocket (MOOP) limits. Moreover, our members are committed to supporting access to comprehensive prescription drug benefits in order to improve the health and wellbeing of employees and their families and to reduce overall health care costs.

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We understand the departments are proposing to codify that prescription drugs in excess of those covered by a state's EHB-benchmark plan are considered EHBs and, therefore, subject to the MOOP limits (as well as the prohibition on annual and lifetime dollar limits). We appreciate that the departments are seeking comment on this proposal before proceeding with codifying this change in the final rule. We also note that our comments are focused on the application of this proposal in the large group insured and self-insured markets, because those are the markets relevant to our members; for the same reason, our comments do not take a position on the application of the rule in the individual and small group markets.

As a foundational matter, we note that we interpret this proposed codification of existing guidance to apply only to the individual and small group insured markets, based on the fact that the additional language is added to regulations that apply only to the individual and small group markets. This reading is also consistent with the fact that when enacting the ACA, Congress deliberately applied different standards to the large group insured market and self-funded plans than the standards that apply to the individual and small group insured markets. For example, individual and small-group insured plans are required to cover EHBs, while this requirement does *not* apply to large-group insured and self-funded plans.

There are policy reasons that support these different standards, including that large group insured and self-funded plans generally are comprised of more sophisticated purchasers with significant bargaining power, many of whom negotiate for specific benefit designs. As a result, the departments provided discretion for large group insured and self-funded plans to identify the EHB-benchmark plan for the application of the MOOP limits. In addition, the departments' FAQ guidance permits large group insured and self-funded plans to offer alternative options within their coverage as non-EHB.[1]

Moreover, avoiding application of this rule change in the large group insured and self-insured markets is not only consistent with the ACA, it also necessary to avoid negative impacts in those markets. While the Council appreciates the departments' goal of increasing access to prescription drug coverage and in mitigating the extent of out-of-pocket costs, we are concerned that if the NBPP 2025 EHB prescription drug rule is extended to large group insured and self-funded group health plans, such plans may be forced to eliminate certain prescription drugs from their formularies due to increased plan costs, including because there is no requirement that these plans cover EHBs. While Council member companies work hard to provide coverage for a broad range of prescription drug therapies, including very costly ones, if cost sharing on all of these drugs must be counted towards the MOOP limits, employers may become unable to

[1] FAQS About Affordable Care Act Implementation (Part XIX), Q&A. 3 (May 2, 2014).

afford covering these drugs at any level, which could have the perverse adverse effect of undermining access to highly valuable prescription drug coverage.

Additionally, extension of this proposal to large group insured and self-funded plans would disrupt carefully planned formularies that are designed to control health care costs by encouraging use of efficacious, lower-cost alternatives. Our members have dedicated years to crafting innovative and robust programs that allow plans to manage and drive down prescription drug costs. In order to reduce spending, these programs rely upon certain medications not being deemed an EHB. If the proposal to expand what is considered an EHB in the NBPP 2025 is finalized without specification of its inapplicability to large group insured and self-funded plans, there will be a significant amount of confusion for such plans and these innovative prescription drug programs may be eliminated.

For all these reasons, if the departments decide to finalize this proposal, we ask that they expressly clarify in the preamble of the final rule that the provision deeming prescription drugs in excess of those covered by a state's EHB-benchmark plan as EHBs does *not* extend to large group insured and self-funded group health plans. We encourage the departments to protect large group and self-funded plans' efforts to design flexible, affordable and comprehensive drug coverage for their enrollees. This acknowledgement in the preamble would bolster, not undermine, enrollees' access to needed prescription drugs and would acknowledge the unique attributes of large group insured and self-funded group health plans that are reflected in the ACA.

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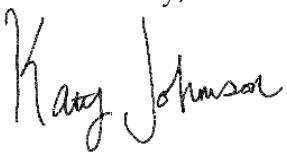
We thank the departments for the opportunity to respond to the proposed rule. We are committed to working with the departments to promote comprehensive and affordable drug coverage for enrollees. If you have any questions or would like to discuss further, please contact us at (202) 289- 6700.

Sincerely,



Katy Johnson
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