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New York, NY 10013

November 12, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–9895–P
P.O. Box 8016
Baltimore, MD 21244–8016

Submitted electronically via www.regulations.gov

RE: File Code CMS-9888-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program ("NBPP") for 2026

Dear Administrator Brooks-LaSure:

Oscar Health ("Oscar") believes the individual market is the market for everyone: the place where consumers have access to innovative, personalized plans, built to meet their needs, and to grow with them over the course of their lives. Oscar is the first health insurance company founded around an end-to-end technology platform and a relentless focus on the consumer to achieve this mission.

In general, we echo the comments proffered by our trade group, AHIP, on this proposed rule. However, because Oscar is a unique player in the individual marketplace, we write to emphasize our particular questions and recommendations regarding plan innovation, grace periods for non-payment, and new risk adjustment factors. Our comments are rooted in ensuring there are meaningful plan choices and more affordable coverage for consumers in the individual marketplace.

1. **CMS should clarify where issuers can innovate within the strict confines of the standard plan.**

While we understand HHS' concerns of consumer choice overload in the individual marketplace, we also believe that consumers benefit from and value meaningful choice and personalized options. As such, Oscar intends to continue to innovate in plan design where possible, both within the two non-standard plan limit and in the exceptions process, which we were grateful to CMS for finalizing in the 2025 payment notice.

However, given those limits, CMS has previously encouraged payers to innovate in their standard plan portfolio. By definition, standard plans offer fixed AV, maximum out-of-pocket (MOOP), deductibles, and cost sharing for a given metal level of coverage. Therefore, CMS's proposal to institute a meaningful difference standard by various criteria in the standard plan is not consistent with our understanding of standardized plans. From our understanding, the only variables that plans can make meaningfully different within the confines of a standard plan are a different provider network and / or a different prescription drug formulary.

CMS should further clarify how plans would be able to vary the following characteristics within the prescribed, identical standard plan design, all of which CMS indicates in the proposed rule would be considered meaningfully different:

1. A different maximum out-of-pocket cap (specifically, an integrated medical and drug maximum out-of-pocket cap versus a separate medical and drug maximum out-of-pocket cap);
2. A different deductible type (specifically, an integrated medical and drug deductible versus a separate medical and drug deductible);
3. A difference in the number of in-network tiers;
4. A $500 or more difference in the maximum out-of-pocket cap;
5. A $250 or more difference in deductible; or
6. A difference in benefit coverage.

2. <u>CMS should further study adopting a fixed dollar limit for grace periods given risks of gaming and fraud.</u>

While Oscar agrees with the intent of CMS' policy goal of adopting a fixed-dollar threshold to avoid triggering a grace period for very low amounts of non-payment, we have concerns that it may lead to unintended consequences, particularly if the threshold is set by the issuer. For example, we have concerns that a fixed dollar limit for a grace period could incentivize bad-acting brokers to game the system by gearing fraud towards the most flexible grace period policies, a particular concern in light of the broker fraud recently observed in the individual marketplaces. We also have concerns that a flexible threshold would also lead to brokers leveraging these unique carrier-specific policies as a marketing lever.

We also have concerns that allowing carrier flexibility with determining a reasonable threshold may result in opportunities for carriers to undermine rate positioning and the rate review process. Without a fixed dollar limit, there could be unintended incentives for issuers to take more credit risks, and therefore also drive them to consider these additional costs into premiums.

Oscar therefore recommends that CMS further study this proposal and its implications before adoption. If CMS intends to adopt a fixed-dollar threshold upon further study, we recommend that CMS set a reasonable maximum dollar threshold rather than allowing flexibility for carriers to adopt their own.

3. <u>CMS should study the current maternity and newborn care factor methodology in risk adjustment models to ensure issuers are not disincentivized from enrolling pregnant members and newborns.</u>

Based on internal and external individual market benchmarks, Oscar has noted that maternity continues to be an undercompensated cohort, regardless of severity, maturity, or complications.

In the Proposed Adult HHS Risk Adjustment Model Factors for the 2026 Benefit Year, several changes appear to continue this trend of undercompensating maternity and newborn care:

1. The year-over-year changes in the proposed Adult Female age demographic factors are less than corresponding year-over-year change in the Adult Male demographic factors (for every age and metal level);
2. The HCC weights for all Pregnancy HCC categories are decreasing year-over-year. For example the change in Silver HCCs related to pregnancy or miscarriages ranges from -4% to -17%;
3. The majority of the infant factors are decreasing year-over-year;

4. Elimination of '(Ongoing) Pregnancy without Delivery with No or Minor Complications' factors for all metals except Platinum.

We also note the unintended consequences of carriers being disincentivized from offering benefits to attract members who are pregnant or may become pregnant. As CMS notes in their Maternal Health Blueprint, the United States maternal mortality rate is the highest of any developed nation in the world and more than double the rate of peer countries. As CMS notes in their Maternity Care Action Plan, pregnancy-related mortality for American Indian and Alaska Native and Black individuals is two and three times higher, respectively, than for white, Hispanic, and Asian/Pacific Islander individuals and nearly 30 percent of Black, Hispanic, and multiracial individuals reported mistreatment while receiving maternity care.

Improving these statistics will take a whole of government and multi-stakeholder approach. As one prong of this solution, maternity care should be better compensated or adjusted in a risk adjustment model, which would encourage issuers to innovate in benefits and member experience to address the disparities and social inequities that pregnant individuals unfortunately continue to face.

We recommend HHS conduct a more formal study and consider alternative methods that would better predict costs associated with maternal and newborn care. At a minimum, the HHS should consider the following:

1. Conducting a study to understand whether the current and proposed model accurately predicts the cost for maternity and newborn care; while taking into account the EDGE submission complexities[1];
2. Whether the submission process for maternity claims and newborn care could be simplified and consistent to ensure all data related to pregnancy, delivery and newborn care is accurately and consistently collected across carriers; and
3. Assessing whether alternative reimbursement methods would better predict costs, or if adjustments need to be made to existing coefficients. Alternative methods could include:
    a. Case-rate kick payments[2] with separate maternity risk pool;
    b. Making unique adjustments to existing coefficients to incorporate both:
        1) considerations for the limitations in the historical EDGE data used to develop the coefficients;
        2) any forward looking trends in maternity costs not captured in the historical EDGE data.

We welcome the opportunity to discuss these issues further with CMS and appreciate the opportunity to formally comment on these proposed rules.

Sincerely,

Alessa Quane
Executive Vice President, Chief Insurance Officer
Oscar Health

[1] I.e., the unbundling of infant and pregnancy delivery claims, as well as eligibility and claims mismatch for infants never enrolling onto the plan despite mandated coverage requirements.
[2] A case-rate kick payment is a supplemental payment made to a plan to cover certain services without the plan assuming financial risk.

About Oscar Health

Oscar Health, Inc. (“Oscar”) is a leading healthcare technology company built around a full stack technology platform and a relentless focus on serving our members. We have been challenging the status quo in the healthcare system since our founding in 2012, and are dedicated to making a healthier life accessible and affordable for all. Oscar offers Individual & Family plans and health technology solutions that power the healthcare industry through +Oscar. Our technology drives superior experiences, deep engagement, and high-value clinical care, earning us the trust of approximately 1.65 million members, as of September 30, 2024.