January 30, 2023

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD
21244-8016

Submitted via regulations.gov.

RE: *Proposed Rule – Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024*

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit the following comments to the Centers for Medicare & Medicaid Services' (CMS) proposed updates to the Notice of Benefit and Payment Parameters (NBPP) under the Affordable Care Act (ACA) for the 2024 plan year.

USofCare is a nonpartisan nonprofit working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives.

After listening to people tell us about their needs for their health care, USofCare released a set of twelve concrete and achievable aims, known as our United Solutions for Care, to help us build a better and more equitable health system. These twelve solutions are derived from four goals for the health care system that continuously rose to the top when talking to people around the country about what works and what is lacking in their health care. People want health care they can depend on, understandable and easy to navigate, affordable, and accessible when and how they need it.

We strongly believe that nobody should have to choose between affordability, access to care, or quality of care, which is why USofCare appreciates CMS's commitment to improving the quality of our health care system through the 2024 NBPP. If finalized, these rules will further a system that better meets the needs identified by people through our research. We appreciate the NBPP as an important vehicle to improve the individual market and health insurance exchanges.

Through our work in states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels. Where possible, we uplift voices of real people engaging with the health care system at the patient level whose input and perspectives have shaped our advocacy work. We focus our comments on the following sections, drawing from our experience working with states on new approaches grounded in people's needs:

1. **Increasing Access to Health Care Services**

2. **Simplifying Choice and Improving the Plan Selection Process**
3. **Making It Easier to Enroll in Coverage**
4. **Strengthening Markets**

Increasing Access to Health Care Services

Network Adequacy and Essential Community Providers

> *"I was looking for some help a while back and trying to find a counselor that was a good fit for me; it took me nine months to get an appointment. Also, there's getting care, and then there's getting the right person you need to feel like you're in good hands. With mental health in particular, some people seek treatment, and then they have negative experiences with an already stigmatized issue."*
>
> White woman living in St. Matthews, SC

People must have sufficient and timely access to providers to support continuity of care, promote strong health outcomes, and ensure health equity. Adequate provider networks and access to essential community providers (ECPs) help individuals receive primary and specialty care services, especially as the high cost of out-of-network services can prevent people from accessing care. **We are strongly supportive of CMS's proposal to require all marketplace plans to meet network adequacy and ECP standards by requiring them to use a provider network.**

We know through our listening work and existing research that despite existing network adequacy standards, many networks remain narrow and may not fully serve the needs of people enrolled, particularly amongst low-income and medically underserved groups. **We applaud CMS's decision from last year that required that plans contract with at least 35% of ECPs and support its proposal from this year to extend that 35% requirement to both Federally Qualified Health Centers (FQHCs) and Family Planning Providers (FPPs) within a plan's service area.** This proposed requirement is notable, as both FQHCs and FPPs represent some of the largest categories of providers used by low-income and medically underserved people.

We are also supportive of CMS's proposal to expand the number of ECP provider categories to include both mental health facilities and substance use disorder (SUD) treatment centers. Most people with mental illness or a SUD do not currently receive treatment, with rates of access to mental health treatment significantly lower for people with lower incomes. Both of these categories were previously listed under the "Other ECP Providers" category. Listing them as distinct categories would ensure that plans attempt to contract with at least one of these providers in a plan area.

Colorado has led the way in addressing the need for culturally responsive provider networks, which stress the importance of strong networks that promote health equity and access to care for all people. This essential component of its innovative "Colorado Option" standardized plan option requires issuers to incorporate at least 50% of ECPs within a plan's service area. We know that ECPs are uniquely positioned to address people's needs and lessen health disparities writ large. **As CMS centers health equity moving forward, we encourage you to raise the 35% ECP threshold to ensure that all people — regardless of race, ethnicity, language, disability status, and additional status — have access to care from a**

provider network that reflects the diversity and lived experience of the community it serves.

Simplifying Choice and Improving the Plan Selection Process

Standardized and Non-Standardized Plan Options

> *"Where does [a] person go to get health care access? After figuring that out, they now have to shop for insurance. Where do they go to do that? Also, if you have health insurance, it may be outlined that it covers one thing, but when you say you need to use it, what you need is no longer covered."*
>
> - Black woman living in Denmark, SC

We strongly support CMS's continued promotion of standardized plans in states that operate their marketplace using the federal platform (both FFMs and SBM-FPs). The standardized benefit packages, defined actuarial values (AVs), uniform deductibles, and similar forms of cost-sharing found in standardized plans will ensure that people can make their own health care coverage decisions without being overwhelmed by too many options. People are desperate to understand coverage selections and often struggle to navigate the system. Promoting the use of standardized plans will empower people to know their options and choose what's best for them and their families.

The aforementioned Colorado Option, in which all issuers offering plans on the state's Individual and Small Group Marketplaces are required to establish a standardized insurance plan, has demonstrated the benefits of these plans in states operating a State-Based Marketplace (SBM). In addition to offering free primary care and mental health visits, people in all of Colorado's 64 counties can find a Colorado Option silver plan at or below the cost of an average silver plan during the PY2023 open enrollment period. Approximately 35,000 Coloradans took advantage of the simplicity of these plans by enrolling in a Colorado Option plan for PY2023.

We are also supportive of efforts by CMS to limit the number of non-standardized plans in states that utilize the Federally Facilitated Marketplace platform (both FFMs and SBM-FPs). The increase in the average number of plans available to people shopping for marketplace coverage has more than quadrupled since PY2019. While people support lower costs associated with a competitive health care Marketplace, having too much choice can be overwhelming for people with limited understanding of the differences between insurance products. We support reasonable limits on non-standardized plans, whether through a general limit of two non-standardized plans per product network type and metal level or the creation of a "meaningfully different" standard to cut down on functionally similar plans.

Requirements for QHP/Variant Naming

We support CMS's efforts to make the plan shopping process more transparent and understandable for people looking to purchase coverage on exchanges. When marketing their plans, issuers should be limited to one cost-sharing feature so as not to overwhelm consumers with too much information. Issuers offering similar plans but with different provider networks should be required to disclose this information to current and prospective enrollees.

Updating the Re-Enrollment Hierarchy

We appreciate CMS adjusting the re-enrollment hierarchy, particularly as new consumer experiences are better understood by policymakers and providers. Although we believe that people should be encouraged to actively enroll in coverage, we do appreciate CMS's focus on this issue, as many individuals opt to be automatically enrolled in coverage for future years.

Current rules emphasize re-enrolling people in coverage at the same metal level as they were enrolled in during the previous year. We appreciate CMS taking a broader view of people's preferences in the proposed rule. **Specifically, we support CMS's proposal to allow marketplaces to modify automatic re-enrollment hierarchies so enrollees eligible for cost-sharing reductions (CSRs) are automatically re-enrolled in plans with the same or lower premiums but have more generous cost-sharing, even though it means the enrollee would move up a metal level.** We also support the proposal to adjust the re-enrollment hierarchy so those eligible for CSRs whose plans are no longer offered are automatically enrolled in plans with the same or similar provider networks. These proposals will ensure people are protected from higher cost premiums and out-of-pocket costs, while also providing further access to similar provider networks.

Additionally, we recommend that CMS modify the re-enrollment hierarchy to focus more on people's "total out-of-pocket costs" than on metal levels and deeply appreciate CMS seeking comment on whether this is a needed change. Premium and out-of-pocket costs are a barrier to coverage and care that disproportionately affect people of color. **Adjusting re-enrollment processes to account for people's total cost of coverage will ensure that more people can afford to stay enrolled in coverage.**

Making It Easier to Enroll in Coverage

Enrolling Through Special Enrollment Periods

Special enrollment periods (SEPs) are critical to providing people with dependable coverage. We appreciate CMS putting forth proposals to allow more access to coverage outside of open enrollment periods.

Loss of Medicaid or CHIP Coverage

More than 15 million people are expected to lose Medicaid coverage once redeterminations begin on April 1, 2023. States are already taking steps to ensure that people deemed no longer eligible for Medicaid coverage have access to other forms of coverage, such as California's plan to auto-enroll these people on Marketplace plans or Oregon's creation of a basic health plan, or "Bridge Plan," for people with incomes up to 200% of the federal poverty level.

We are encouraged by CMS's consideration of proposals preventing any lapse of coverage for people no longer eligible for Medicaid or CHIP and support CMS's recent announcement of an SEP through July 31, 2024 for people who lose Medicaid or CHIP due to the "unwinding" of the continuous enrollment condition first established under the Families First Coronavirus Response Act. More generally, we appreciate that CMS is considering changes to extend the length of an SEP following the loss of Medicaid or Children's Health Insurance Program (CHIP) coverage to 90 days. While we support a longer SEP in this situation, we are concerned that 90 days is not enough time to ensure people don't have gaps in coverage. **We urge CMS to extend the SEP window for people losing Medicaid or CHIP coverage to at least 120 days following loss of coverage.**

Plan Display Errors

Currently, people who have experienced a "plan display error" that displays incorrect information related to its plan benefits, service area, or premium during the plan selection are eligible for an SEP, should they be able to show that the incorrect information affected their plan selection and enrollment process. **We are supportive of CMS's proposal to lift the burden of proof to additionally allow regulators and other "interested third parties" to demonstrate that a plan display error affected a person's plan selection.** Furthermore, given that deductibles and other out-of-pocket costs represent a significant financial burden for people, we encourage CMS to add cost-sharing requirements to the list of potential plan display errors that could trigger an SEP on these grounds.

Mid-Year Provider Network Changes

From time to time, certain circumstances lead providers to leave a plan's provider network. These changes cause confusion and frustration for people who rely on these providers who may suddenly be out-of-network. **We support CMS's proposal to establish an SEP for people who see their providers leave their network mid-year.** While we understand some people, especially those with high deductibles and other significant forms of cost-sharing, may not find switching plans during the SEP to be financially feasible, the CMS proposal represents a new option for people who, through no fault of their own, may lose their preferred provider.

Resolving Data Matching Issues

We support CMS's proposed changes that make it easier for people to enroll in coverage when they experience a "data matching issue" (or DMI), as current processes are burdensome both for consumers and for exchanges. Specifically, **we support the proposed changes allowing people who have DMIs to have more time to enroll in coverage. We also support the proposal to permit people to attest to their income when there are inconsistencies with IRS data**.

Ensuring Continuity of Coverage for Young Adults

Because they are, on average, healthier than older people, young people tend to have lower rates of health insurance coverage. The ACA's requirement that young adults up to age 26 can remain on their parents' health plan has increased coverage rates; to lock in these gains, the Federally Facilitated Marketplace requires issuers to continue this coverage for young adults turning 26 through the end of that plan year. **We support the proposal to prohibit QHPs from terminating coverage of dependent children before the end of the coverage year in which they turn 26, in order to ensure continued coverage for this population at risk of losing coverage.**

Improving Outreach and Enrollment Assistance

We strongly support the work of navigators who provide critical outreach and enrollment assistance to people nationwide. For many who don't have the time or expertise to sift through hundreds of plans, navigators play a critical role in helping people understand their options and identify a plan that works best for them, their families, and their individualized health needs. **While we appreciate the spirit of CMS's proposal to allow first-contact door-to-door and over-the-phone ("cold-calling") enrollment assistance, we are concerned that this form of outreach may allow scam artists to take advantage of**

people, especially older populations. As Medicaid redeterminations are set to begin April 1 of this year, we encourage CMS to continue their investment in established methods to ensure that people losing Medicaid coverage have access to coverage options through the navigators and other enrollment assistance personnel.

Strengthening Markets

Lowering Marketplace User Fees

Under this proposal, states that utilize a Federally Facilitated Marketplace (FFMs) would see their user fees drop from 2.75% to 2.5% of total monthly premiums, while states with State-Based Marketplaces that use the federal platform (SBM-FPs) would see their user fees drop from 2.25% to 2%. While this reduction is encouraging news and a sign of increased enrollment and related user fees, CMS must ensure marketplaces can fully operate and serve consumers. We know that people want a health care system that is easy to understand and navigate, and marketplaces help move towards this by providing critical enrollment assistance and outreach. To that end, **CMS should finalize the proposed changes to user fees for FFMs and SBM-FPs and establish processes to monitor whether the lower user fees fully serve people's needs moving forward.**

Additionally, while not the focus of the proposed rule, we appreciate CMS's work to support states with a State-Based Marketplace (SBM) and encourage continued dialogue with states interested in making the transition to better understand their needs. As more states look at creating SBMs, CMS can learn from these experiences and should explore whether reestablishing the federal SBM user fee floor is needed. For example, when Maine recently transitioned from the FFM to the SBM, they tied their user fees to the 3% federal user fee level in place when their legislation passed to fully cover operations. While a 3% floor may be too high for all State-Based Marketplaces, establishing a minimum floor for SBM user fees will provide stability and protections for State-Based Marketplaces and will allow them to continue providing robust services to consumers, including outreach and enrollment assistance.

Conclusion

Thank you for the opportunity to respond to the proposed updates to the NBPP for the 2024 plan year. USofCare believes that these updates, if finalized, can build towards our mission of ensuring everyone has access to quality, affordable health care. We are grateful for the space to share the lessons learned from our work listening to people and our earned expertise from our unique approach to state work. If you have any questions or are interested in further discussion of the proposed updates, please reach out to Eric Waskowicz, Policy Manager, or Liz Hagan, Director of Policy Solutions, at EWaskowicz@usofcare.org or EHagan@usofcare.org.

Sincerely,

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Co-Founder & CEO
United States of Care