January 8, 2024

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

Submitted via regulations.gov.

RE: "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program" [CMS-9895-P]

Dear Administrator Brooks-LaSure,

United States of Care (USofCare) is pleased to submit comments to the Center for Medicare & Medicaid Services (CMS) regarding the Notice of Benefit and Payment Parameters (NBPP) for Calendar Year 2025.

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. 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.

The 2025 NBPP builds upon the strong consumer and health equity protections established in last year's final rule to ensure that everyone has access to comprehensive, affordable health care. USofCare applauds CMS's continued focus on addressing the systemic health disparities people face in our health care system in this year's NBPP. It is critical that our health care delivery system center the needs of individuals and communities that face the greatest barriers to accessing and utilizing health care as we consider policy solutions to drive health equity. If finalized, the 2025 proposed rule would continue to put people first and incorporate recommendations submitted by USofCare and others in last year's Request for Information (RFI) on Essential Health Benefits.

Overall, USofCare supports language within this year's NBPP that centers the patient experience and ensures that people are able to use their health insurance when they need it. We are particularly supportive of provisions within the proposed rule to standardize coverage requirements across states and seek to streamline the enrollment process for millions of people no longer deemed eligible for Medicaid as part of the redetermination process.

Where possible, we uplift the voices of people whose perspectives on their experiences with the health care system shape our advocacy work, focusing our comments on:

I. **Strengthening Essential Health Benefits**
II. **Improving State-Based Marketplace (SBM) Operations**
III. **Streamlining Enrollment and Coverage Policies**

Strengthening Essential Health Benefits

The Affordable Care Act's (ACA) Essential Health Benefit (EHB) provisions have expanded people's access to comprehensive coverage since the ACA's passage in 2010. Prior to the EHB requirements, coverage of many critical services was spotty at best. For example, 62% of people didn't have coverage that included maternity services, 34% didn't have coverage for substance abuse services, and 18% didn't have coverage for mental health care services. Since then, the EHB requirements have allowed people, especially those with low incomes, to benefit from coverage that more fully addresses their health care needs. Furthermore, coverage of the ten required EHB services have helped reduce health care disparities for people who have historically been marginalized by the health care system, including Black, Indigenous and people of color (BIPOC) and the LGBTQ+ community.

State Benchmark Updates

Unfortunately, the variable nature of the state EHB benchmark process in determining a reference plan for covered benefits under the EHB framework has led to a lack of uniformity in coverage across states. While every state selects a benchmark plan that covers the ten EHB categories, the comprehensiveness of the coverage within these benefit categories can vary drastically.

In order to address gaps in coverage, USofCare supports efforts to simplify the process through which states select and/or update their benchmark plans. The proposed changes will allow states the ability to update their benchmark plans to add new coverage requirements, which relatively few states have taken advantage of within the current framework. CMS's proposal merges the two existing scope-of-benefit standards, which are often seen as burdensome for states, and effectively introduces floor and ceiling standards for potential EHB coverage that are either more generous than the state's least generous typical employer plan or no more generous than the state's most generous employer plan. These changes will incentivize additional states to improve their benchmark plans to address gaps in coverage, similar to efforts to cover gender-affirming care in Colorado or weight loss medications in North Dakota. **To minimize the administrative burden of this transition, we urge CMS to consider aligning these changes, planned for plan year 2027, with other EHB-related changes outlined below scheduled to take effect during plan year 2025.**

Importantly, any changes to a state's benchmark plan should also apply to the process through which a state selects a benchmark plan used to determine EHBs in a Medicaid Alternative Benefit Plan (ABP) or Basic Health Plan (BHP) standard health plan. **We are supportive of efforts by CMS to continue to align benefit design and coverage standards across these plans so as to minimize confusion for people switching between these plan options.** Our listening work has shown time and time again that people desire a health care system that is understandable, and as millions of people across the country transition off Medicaid during the redetermination process and onto Marketplace plans, it is critical that states take all opportunities to align these two coverage options so that people maintain access to needed services during this period.

Cost Defrayal
State EHB packages were never meant to be static, although worries that states would be responsible for defraying the cost of additional coverage outside those considered EHB have limited state efforts to expand coverage options. In 2018, CMS determined that additional coverage mandates adopted through the standard benchmark process would not be subject to cost defrayal rules, even if they existed outside the original ten benefit categories. **We support language that expands this determination to ensure that additional benefits already included in the EHB benchmark plan chosen by the state would not be considered "new benefits" subject to cost defrayal.** We believe this, when paired with the proposed rule's benchmark plan selection flexibilities, will encourage states to expand access to benefits, such as substance use disorder treatment, without fear of incurring additional costs through defrayal. By ensuring these additional benefits are considered EHBs, these additional benefits would also be subject to EHB non-discrimination rules and consumer protections like restrictions on annual or lifetime dollar limits, further benefiting the people who have come to depend on these services.

Adult Dental and Adult Vision Services
While the ACA included pediatric dental benefits as one of the ten EHBs, federal regulations outlining the benchmarking process have expressly prohibited plans from offering non-pediatric, adult dental health benefits as EHBs. This exacerbates existing disparities in access to dental care and insurance coverage more generally. For example, while the ACA pushed the national traditional medical uninsured rate to a record low in 2023, more than one in four people still do not have dental coverage. A lack of coverage only perpetuates oral health disparities, which already disproportionately impact low-income older adults and communities of color, particularly Black and Latino people. Furthermore, people without dental coverage can be at higher risk of complications during pregnancy.

> *"Why is it that you have major medical insurance, but dental and vision isn't covered? Because somehow you don't need teeth?"*
> *~ White man, New York*

Since the ACA's passage in 2010, employer plans have increasingly expanded coverage of adult dental care. In our February 2023 response to CMS and the Department of Health and Human Services's (HHS) RFI regarding EHB, we called on the Departments to "think creatively… in how it can further expand access to adult dental care through EHB." **To that end, we applaud CMS for removing the adult dental EHB restriction to allow states to include adult dental care in their EHB benchmark plans.** Although the proposed rule does not require coverage of adult dental benefits through EHB, we are hopeful that, given the prevalence of adult dental benefits in many employer plans, many states will adopt this coverage benefit through the benchmarking process and begin chipping away at documented oral health disparities nationwide. Should a state choose to update their benchmark plan to include adult dental services as an EHB, we recommend that health plans ensure that any transition process be seamless for people who already have adult dental coverage.

> *"It's just astonishing to me that you can't just go to a government website and type in how to get [dental care] or how to find a low-cost dentist. There needs to be somewhere for you to understand where to find assistance for dental services."*
> *~ White man, Illinois*

Similarly, we urge CMS to take the same approach to adult vision and remove EHB restrictions on these critical services. We know similar equity concerns apply to vision health as with oral health. Removing the EHB adult vision restrictions will improve disparities in access for communities of color and additional marginalized populations typically underserved by the health care system. Notably, rates of visual impairment are higher among communities of color and are associated with increased injury risk, social isolation, and premature death. Therefore, we support CMS removing prohibitions for states to include these services in their EHB requirements, which will provide states with the flexibility to evaluate and respond to the needs of their residents.

Areas of Focus for the Future

We encourage HHS to establish a process through which it periodically reviews and updates EHB requirements. While this process is required by the ACA, HHS has not yet convened a working group to do this. While we understand that states are allowed significant flexibility to build upon EHB requirements through the benchmarking protocol, a comprehensive, HHS-led review process would allow the Department to rigorously examine the EHB process and identify any gaps in coverage that remain. Much has changed since the ACA's passage in 2010 that could benefit from HHS review; for example, the opioid crisis has reshaped our understanding of substance use treatment, and a greater emphasis on mental health has proven the value of behavioral health care services.

All EHB categories would benefit from regular review that incorporates outside perspectives, health equity concerns, and the latest data to ensure that EHBs remain relevant and reflective of the most recent medical and coverage advances. **Beyond the standard public review and comment protocol, any process for review of EHB should meaningfully incorporate the needs of everyday people, and should, in particular, uplift the voices of people who have historically faced barriers to health care.** Centering their experiences will ensure that people who stand most likely to benefit from EHB protections will actually do so.

Finally, we echo our recommendation made in the February EHB RFI and urge CMS to explore ways to incorporate doula care within EHB. Our listening work reveals that Black women and women and birthing people of color can identify ways in which doula care can improve their birthing experience, but cost and coverage are barriers. Doula care is not explicitly included in any state benchmark plan, with some states even restricting or excluding doula care as part of their benchmark. Incorporating doula care within EHB will further expand access to care and reduce maternal health disparities, in particular for Black people, who have disproportionately experienced trauma, discrimination, adverse health outcomes, and maternal deaths throughout their birthgiving journey at dangerous rates.

Further Improving State-Based Marketplaces (SBMs)

State-Based Marketplaces (SBMs) give states more tools to enhance the consumer enrollment experience for those purchasing coverage in the individual market compared to that of the Federally-Facilitated Marketplace (FFM). The number of states (currently 18, in addition to the District of Columbia) providing Marketplace coverage through SBMs is increasing, demonstrating positive results. Georgia and Illinois are set to make the switch for plan year 2025, while Wisconsin and Michigan are actively deliberating similar legislative action. **USofCare applauds CMS for its efforts to improve processes for states transitioning from the FFM to a SBM and for creating national, uniform standards that establish more consistent consumer protections across states.**

SBM Transition Processes

USofCare is supportive of the proposed requirement that states aiming to transition to SBM status must operate as a SBM utilizing the federal platform (SBM-FP) for at least one year before fully transitioning to a SBM. As the proposed rule notes, every state since plan year 2020 that has transitioned to a SBM has utilized the SBM-FP model for one or more plan years. This requirement will provide states looking to transition away from the FFM with the time necessary to adequately staff and support its SBM models and ensure that the consumer experience remains uninterrupted. Moreover, such a transitory period provides additional opportunity for stakeholder and community engagement to ensure that state plans are structured in a way that best meets the needs of current and future enrollees.

While we appreciate the updates made to the SBM approval process and the Exchange Blueprint, slight improvements will strengthen these processes even further. For example, the proposed rule allows CMS to ask states to include detail in their Blueprint about how they will conduct consumer assistance programs, including direct outreach plans. We urge CMS to add uniform requirements for states submitting Exchange Blueprints so there is transparency about the details of new exchanges before they are approved. This would provide critical information about funding for enrollment assistance, for example, that CMS should take into consideration before approving a state's transition from the FFM to a SBM. **We also urge CMS to consider further requirements for the stakeholder engagement process in order to maximize public input.** This could include the number of stakeholder meetings the state must conduct, minimum notice for upcoming stakeholder engagement, protocols for language and accessibility services, meeting times outside of traditional working hours, and options for virtual or phone-only meetings.

Open & Special Enrollment Periods

> *"Each year during open enrollment, we should get a sheet of paper that describes deductibles, in network, out of network, and all of that… I just think it is so confusing."*
> *~ Black woman, Michigan*

Most SBMs host open enrollment periods (OEPs) that mirror the FFM OEP of November 1 through January 15. While several states offer an even more generous window through the end of January, not all do. **We support CMS's proposal to require states to adopt an open enrollment period that begins November 1 and ends no earlier than January 15.** We agree with CMS's rationale that this provision will reduce consumer confusion around when they can enroll in coverage, while providing states with the flexibility to extend their OEP past January 15 if they so choose.

Additionally, the rule ensures that SBMs provide the same coverage effective dates as the FFM for people enrolling through special enrollment periods (SEPs) with incomes at or below 150 percent of the federal poverty level (FPL). Doing so will ensure that eligible enrollees will be able to receive coverage the first day of the following month, regardless of when in the previous month they enrolled. In turn, this allows for more people to become enrolled in life-saving coverage more quickly, minimizing coverage gaps. **We urge CMS to broaden the income limit for this SEP to allow states the ability to better align with Medicaid and CHIP income eligibility limits in each particular state, especially during the Medicaid eligibility redetermination process, to minimize coverage disruptions.**

Outreach & Enrollment Assistance

USofCare supports the initiatives to improve the consumer enrollment experience featured in the NBPP. Establishing standards for SBM call centers, as well as the web-brokers and direct enrollment (DE) entities working in SBM jurisdictions, ensure that consumers have greater access to the information and support they need to select a plan that works best for them. **To strengthen the proposed changes, we recommend CMS provide additional guidance to establish language-specific phone lines to support people with disabilities and/or proficiency in a language other than English and establish minimum standards for call center wait times to streamline the enrollee experience.**

Furthermore, we commend CMS's proposed oversight of DE entities in SBMs to ensure people living in states with a SBM are shielded from misinformation and afforded the same protections as people living in states with the FFM. Far too often, many DE entities may enroll people in coverage they're not eligible for or in plans that don't meet their unique health care needs. **To address this, we support CMS's proposal clarifying that exchanges – as opposed to DE entities – have the final decision-making authority regarding people's eligibility status. We also support the proposal requiring SBMs to operate a centralized enrollment and eligibility platform on their website that would allow people to continue an application they began with a DE entity to allow additional flexibility for people.**

> *"You have a car accident, and a car insurance company kind of takes you through every step of the process, from getting your car fixed to what happens to the other car. Wouldn't it be fantastic if a patient navigator could just take you through the whole process?"*
> *~ Asian woman, Maryland*

Minimum Network Adequacy Standards

USofCare strongly supported language in the 2023 NBPP final rule that reinstated network adequacy standards and quantitative standards for network access, such as maximum appointment wait times and time and distance standards, for plans offered on the federal exchange. **Because we believe these standards have facilitated greater access to care and have improved health equity, we support the proposal that SBM and SBM-FP time and distance network adequacy standards be "at least as stringent" as those of the FFM.**

The proposed rule strives to remedy the fact that some SBMs and SBM-FPs do not have quantitative time and distance network adequacy standards for eligible quality health plans (QHPs). This leads to narrower provider networks, meaning that people have fewer options of where they can receive care that is covered by their plan. People are more likely to skip or delay care if they cannot afford it, including care that is not already covered by their plans. Additionally, people cannot access care if they do not have the ability or means to travel to a medical provider, which disproportionately impacts people of color, rural communities, and additional marginalized groups. The proposed rule establishes certain basic network adequacy expectations to ensure people have understandable and accessible care, regardless of if their state utilizes a SBM, a SBM-FP, or a FFM model. **Moving forward, we also encourage CMS to similarly apply FFM requirements for appointment wait time standards to SBMs and SBM-FPs.**

It is important that CMS considers how to best implement the proposed rule in SBM states that have more stringent time and distance standards than those on the FFM. States that incorporate more stringent network adequacy standards for specific standards, like Minnesota and New Jersey, should be encouraged to maintain standards beyond the proposed federal SBM minimum standards and should not face any barriers to maintain or improve upon them. **What's more, we encourage CMS to look to states for innovative solutions to improve network adequacy standards beyond what's listed in the proposed rule**. For example, Colorado's culturally responsive networks are working toward building a system of providers to better validate, understand, and affirm the diversity and experiences of their enrollees. Plans nationwide would benefit from efforts, like those found in Colorado, to use network adequacy standards to reduce racial health disparities and improve equity.

Telehealth

> *"I liked [my experience with virtual care] a lot…and I hope they continue it after COVID is done. You know, for certain situations. Maybe one time a year you would go in for the physical and lab work, but the rest could be virtual. It's been a very good experience."*
> *~ Person with a Disability*

A well-designed approach to telehealth services has the potential to break down long-standing barriers to health care access, especially for people who have historically lacked access to this sort of care. In recent years, people have increasingly been able to access needed services at home and in other settings that make sense for them through telehealth. We appreciate HHS' commitment to further understanding how telehealth services can improve access to care by centering community voices by holding regional listening sessions in multiple languages and establishing trusted community partnerships. **At the same time, we strongly support the proposed rule's clarification that telehealth services may not be counted in place of in-person health care for the purpose of satisfying network adequacy standards.** Many people continue to lack access to the broadband internet that facilitates telehealth services. Furthermore, allowing plans to meet network adequacy standards with telehealth services robs people of the chance to choose whether in-person or telehealth health care works best for them.

Streamlining Enrollment and Coverage Policies

Improving Eligibility & Enrollment Policies

We appreciate CMS's efforts to make FFM enrollment and renewal processes easier and more transparent. **We support CMS finalizing proposed rules to improve eligibility and enrollment policies**, including establishing new rules for marketing, providing notice to enrollees who fail to reconcile their taxes, providing states with options for coverage effective dates for BHP enrollment, and creating requirements for re-enrolling people in coverage when they don't actively select a plan. These new marketing rules, for example, will improve the consumer experience and empower people to compare plans and make the best decision for them and their family. Many people feel overwhelmed by too many choices and simply want a better understanding of their options, so we support the improvements included in these proposed rules. As we look forward, we continue to urge CMS to take a comprehensive look across all affordability programs to ensure people don't face barriers to enrolling and keeping coverage, whether it is Medicaid, CHIP, or Marketplace coverage.

1332 Waiver Transparency

We appreciate CMS updating the requirements for 1332 waiver stakeholder engagement processes by allowing states to hold virtual or hybrid meetings without being granted special permission from CMS. We believe these changes will allow for more robust engagement from a more diverse cross-section of stakeholders who would otherwise be unable to attend due to logistical challenges, such as transportation and child care. **Given the unique accessibility challenges faced by people who are blind, Deaf, hearing impaired, and/or proficient in a language other than English, we encourage CMS to share additional guidance with states looking to ensure these people are able to meaningfully participate in the stakeholder engagement process.**

FFM & SBM-FP User Fees

We support CMS's proposal to maintain 2024 exchange user fees for the 2025 plan year for FFMs and SBM-FPs. We understand the rationale for CMS lowering Exchange user fees in the past due to more constant enrollment, and we implore CMS to thoughtfully consider the enrollment and access impact lowering user fees will have before making any future changes.

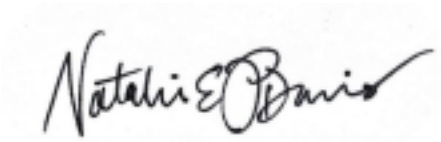
Standardized Plans

We have been supportive of CMS's previous efforts to strengthen standardized plans and appreciate steps CMS has taken to encourage the adoption of standardized plans in SBMs. **Like CMS, we see the benefits of standardized plans for people in SBMs that have them, and therefore urge CMS to require issuers to offer standardized plans in SBMs.** These can be designed to meet people's needs and reduce disparities in access, which can be seen through access to free primary care and behavioral health care services for those enrolled in Colorado's standardized Colorado Option plans. CMS will have a critical role to play in ensuring similar consumer protections are in place for standardized plans operating in both the FFM and SBMs.

Conclusion

Thank you for the opportunity to respond to the proposed updates to next year's NBPP. The proposed rule, if finalized, will build towards USofCare's mission to ensure that everyone has high-quality, affordable, personalizable, and understandable access to care and we are grateful for the space to share the lessons learned from our work listening to people speak about their health care challenges. Please reach out to Lisa Hunter, Senior Director for Policy & External Affairs, at LHunter@usofcare.org with any questions.

Sincerely,



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