January 8, 2024

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.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:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to submit recommendations to support enhanced consumer experience and greater efficiency in the marketplace in response to the proposed 2025 Notice of Benefit and Payment Parameters (NBPP).

ACHP is the only national organization promoting relationships between innovative health plans and providers that deliver affordable, high-quality coverage and care. ACHP member companies are non-profit community-based, provider-aligned health plans that provide coverage in all lines of business for tens of millions of Americans in nearly 40 states and the District of Columbia. Its member health plans are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data driven systems improvement.

Consumers deserve a robust market with fierce competition and broad choices. ACHP strongly supports proposals to increase consumer choice and provide individuals with opportunities to enroll in coverage. Particularly, Medicaid eligibility redeterminations will prompt consumers to navigate the Marketplace for coverage that meets their needs, many for the first time. We offer feedback to ensure policies further competition and serve consumers without adding unnecessarily burdensome operational challenges.

Network Adequacy

ACHP requests CMS delay or revise requirements for establishing quantitative time and distance standards for State-Based Marketplaces on the federal platforms (SBM-FP). We appreciate the Administration's efforts to ensure all consumers, regardless of locality, have timely access to providers. However, the existing time and distance evaluation framework does not provide meaningful information about enrollees' actual access to care and is based on an outdated framework that assumes all care is delivered in person by providers in atomized facilities.

ACHP requests CMS delay or revise implementation timelines for quantitative time and distance standards for State Marketplaces and SBM-FPs to 2027 calendar year. The January 1, 2025, timeline proposed in the rule is aggressive and does not give states enough time to make necessary regulatory changes to accommodate federal requirements. These processes typically take two years. We request that CMS delay implementation of these proposals until 2027. Additionally, ACHP requests CMS delay or revise implementation timelines for quantitative network adequacy reviews. The proposed effective date does not provide sufficient time for states to evaluate if their existing network adequacy requirements are sufficient or if they will request an exception. Further, this timeline does not give insurers adequate time to contract with providers to meet any new requirements, especially if they are unclear as to whether their state will seek an exception.

ACHP requests a larger review of network adequacy standards across lines of business to ensure greater consistency nationally, as well as across different programs within CMS. Current quantitative time and distance requirements are inadequate measures of consumer access. It would be counterproductive to build an already antiquated model to scale across different marketplaces. It would be more imperative for states to develop a methodologically sound, administratively feasible and sustainable state-based process for determining network adequacy than to require a potentially complex comparison between state and federal requirements. Furthermore, annual updates to the federal standards could disrupt the state-level network adequacy oversight strategy.

ACHP recommends CMS evaluate the impact of enforcing a separate set of network adequacy standards for Qualified Health Plans (QHPs). Most states that operate their own exchanges have robust existing network adequacy standards comparable to the commercial market. Creating a separate standard for QHPs operating on State Exchanges and SBM-FPs will bifurcate the market, adding additional administrative complexity without additional benefit for consumers.

ACHP recommends CMS consider the disruptions that could result from a separate network adequacy review process for QHPs on State Exchanges and SBM-FPs. Imposing a new set of federal standards along with a required review process for State Exchange and SBM-FP network adequacy standards creates additional complexity and may create confusion and uncertainty for insurers, especially if standards and expectations vary between state and federal regulators.

ACHP requests CMS take telehealth into account for network adequacy reviews. Although time and distance standards have been regarded as the gold standard for assessing access, the increased utilization of virtual care during the public health emergency has transformed how patients access and interact with the health care system. Incorporating telehealth in network adequacy reviews would afford more accurate assessments of provider availability, especially for patients in rural settings that rely more on telehealth for their health care needs.

Overall, the network adequacy proposals in this proposed rule would beget major policy shifts that would undermine the ability of states to administer state marketplaces that best meet the needs of their enrollees. State regulators are in the best position to determine network adequacy standards that should apply to the health plan markets in their states, considering unique market dynamics and availability of providers and provider types.

Non-Standardized Plan Options

ACHP requests CMS revise currently proposed exceptions process criteria to facilitate ease in implementation and increase consumer choice for non-standardized plan options. The exceptions process, as currently proposed, is a lengthy and cumbersome process. The current proposal requires plans to submit evidence of a reduction in cost-sharing by 25 percent for chronic condition plans. Chronic conditions typically present higher utilization. Compounded with inflation and increased health care spending, this figure seems unobtainable.

We appreciate CMS' proposal of an exceptions process for non-standardized plan options, beyond the limit of the two, so long as the plans have distinct benefit designs that address high-cost, chronically ill enrollee needs. This adjustment signals CMS' acknowledgement that there is demand for more options to meet the unique health needs of individuals that require complex care. However, we request a revised exceptions process with requirements that would be more feasible to satisfy, and in turn bolster consumer choice.

Additionally, we request CMS postpone implementation of the limit of two non-standardized plan options until 2026, to understand how the current proposed changes have impacted consumers. Postponing the requirements to limit non-standardized plan options from *four* to *two* offerings would provide CMS with more data to glean whether these changes produced the intended effect of reducing consumer confusion in the plan selection process. We caution that continuing to limit non-standardized plan options may impede innovation in plan design.

Prescription Drug Coverage

ACHP recommends that consumer representatives serving pharmacy and therapeutics (P&T) committees meet existing committee membership criteria or be barred from voting rights. We are concerned with the proposal to add a consumer representative to issuer's P&T committees, because it could open the door to allowing individuals with ties to drug manufacturers to influence formulary coverage. Although the proposal includes conflict-of-interest provisions, those should be strengthened to ensure that an individual has no link (direct or indirect) to a drug manufacturer. We also anticipate that it will be challenging to recruit a consumer representative who meets the stated criteria to appropriately weigh in on the complex issues raised during committee meetings. We request that plans are held harmless if good faith efforts are made to recruit a public member, but no qualified applicants are available.

ACHP recommends CMS evaluate the impact on coverage expansion and rising costs of certain medications with the transition to the USP Drug Classification (DC) system. We anticipate the impact of replacing the United States Pharmacopeia (USP) Medicare Model Guidelines (MMG) with the USP DC system could significantly raise costs for members via premiums, as well as significant health plan spending to accommodate additional drugs covered. Using the USP DC as the drug classification system would increase the number of drug classes required to be included in health plan formularies (e.g., weight loss, infertility, and sexual dysfunction), many of which are currently excluded from formularies.

Re-Enrollment Hierarchies

ACHP requests CMS delay codifying requirements prohibiting Exchanges from auto re-enrolling individuals currently enrolled in coverage of a metal level into catastrophic coverage. We request CMS delay these proposals to ensure that states have time to create and implement any potentially new rules and guidance around mapping logic. Health plans would benefit from working with their state exchanges to facilitate a smooth implementation of new logic, especially considering the ongoing influx of new or returning individuals purchasing insurance on the exchange following the Medicaid redeterminations process.

ACHP supports mechanisms that encourage individuals with catastrophic coverage to maintain coverage by cross-walking in a similar way to silver re-enrollment rules. Additionally, we support mechanisms that encourage individuals who age out of catastrophic coverage to transition to comprehensive medical coverage. This would benefit consumers as well as potentially help stabilize the individual market.

Special Enrollment Period for Advance Premium Tax Credit (APTC)-Eligible Qualified Individuals

ACHP requests additional time to evaluate the impact on premiums before removing the limitation that the Special Enrollment Period available to qualified individuals only be available during periods where APTCs are available. We have concerns regarding adverse plan selection and impacts on the risk pools following implementation of this proposal. We strongly support increased access to APTCs, however, recommend that CMS delay this proposal to gather an additional year of data.

Essential Health Benefit (EHB) Benchmark Plans

ACHP requests CMS evaluate the impact the proposed changes for EHB requirements could have on adjustments to the EHB defrayal policy. We are concerned that rather than putting more guardrails in place to monitor a state's penchant to ask health plans to cover more with less, these provisions would make it easier for states to pass new mandates and ensure they are not "in excess of EHB" simply by adding them to the state's benchmark plan. This, coupled with CMS' recent interpretation that states are solely responsible for determining what is in excess of EHBs,

all but nullifies the defrayal rules. States have no incentive to find something in excess, and CMS is not serving as a check on this process – nor do issuers get any transparency or input into the process.

Given the sheer volume, this failure to institute a check on new state mandates could significantly impact the overall costs of health coverage. We are especially concerned with the per member per month projections for fertility services and weight loss drugs. And if enhanced APTCs expire in 2025, this problem will be exacerbated because many more consumers will not be insulated from the inevitable premium increases.

State Flexibility to Use Income and Resource Disregards for Non-MAGI Medicaid Eligibility

ACHP supports proposals to provide states with increased flexibility to determine financial eligibility for Non-Modified Adjusted Gross Income (MAGI) populations. Through our commitment to increase access to coverage and equity, we support the provision allowing states to request changes to income methodologies for non-MAGI members. It will be critical for CMS to carefully monitor this flexibility to assure that states are using it to expand access to coverage and that the requests received from states interested in this flexibility are in the expansion versus contraction of coverage space.

Conclusion

ACHP member companies are committed to preserving access to quality and affordable care, through a highly functioning and stable individual and small group market. We welcome additional opportunities to engage with the Administration to ensure an affordable and accessible individual market that provides coverage options for all. Please contact Nissa Shaffi, Associate Director of Public Policy, at nshaffi@achp.org, with any questions or to discuss these recommendations further.

Sincerely,

Dan Jones

Dan Jones
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Alliance of Community Health Plans