

January 8, 2024

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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 Secretary Yellen, Secretary Becerra, and Administrator Brooks-LaSure:

The American Kidney Fund appreciates the opportunity to provide comments on the proposed rule referenced above issued by the Department of the Treasury, the Department of Health and Human Services (HHS), and the Centers for Medicare and Medicaid Services (CMS).

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

AKF supports several of the policies in this proposed rule. We appreciate CMS's commitment with this proposed rule to expanding access to quality, affordable health coverage and care, increasing access to health care services, simplifying choice and improving the plan selection and enrollment process, and enhancing standards and guaranteed consumer protections. We believe many of the proposals in this rule will advance those goals. We offer the following comments and recommendations on specific provisions of the proposed rule.

Network Adequacy

AKF appreciates CMS's continued implementation of strong network adequacy standards in the Federally-facilitated Marketplaces (FFMs), which are necessary to achieve health equity and to enhance consumer access to quality, affordable care through the marketplaces. We continue to support the evaluation of plan networks using quantitative time and distance standards, and we support CMS implementation of wait time standards in 2025. We also support CMS's requirement that insurers identify whether their providers offer telehealth services, and we support the requirement that all marketplace plans use a network and comply with all network adequacy standards.

Therefore, we strongly support CMS's proposal in this proposed rule that for plan years beginning on or after January 1, 2025, State-based Marketplaces (SBMs) and State-based Marketplaces on the federal platform (SBM-FPs) establish and impose quantitative time and distance qualified health plan (QHP) network adequacy standards that are at least as stringent as the FFMs' time and distance standards. Requiring all plans on all marketplaces to comply with minimum federal network adequacy standards will ensure consumers can better compare plan options, reduce their risk of exposure to high cost sharing, and ensure consistent enforcement of ACA consumer protections.

To further strengthen CMS's network adequacy standards for FFMs, SBMs and SBM-FPs, we reiterate our recommendation that CMS require networks be evaluated for how well they provide access to culturally and linguistically appropriate care. The evaluation would ensure providers can meet the language needs for consumers with limited English proficiency and provide culturally appropriate care that is attuned to the diverse background of a community, including populations that have been traditionally underserved.

We recommend that CMS strengthen standards and improve oversight of plan provider directories to ensure they are up-to-date and accurate, which is critical in helping consumers make informed decisions in choosing a plan. We also recommend that provider directories be required to indicate the languages, other than English, that providers and/or their staff speak; the accessibility of a provider's office; and the telehealth capabilities of participating providers.

Finally, we recommend that dialysis facilities be included in the list of facility specialty types in which network time and distance standards apply. We appreciate that nephrology and vascular surgery are included in the list of provider specialty types in which time and distance standards

apply, but dialysis is also a critical and necessary part of the continuum of care for people with kidney disease, and that should be reflected in the network adequacy standards.

State-Based Marketplace Standards

AKF appreciates and supports several of CMS's proposals that would establish federal minimum standards for SBMs and states looking to transition to an SBM. We believe these proposed standards would help ensure that consumers in FFM and SBM states benefit from marketplace policies that serve the best interest of patients and consumers. Specifically, we support the following CMS proposals:

- Require states seeking to transition to an SBM submit supporting documentation to HHS through the Exchange Blueprint process, and Blueprints must be approved by HHS.
- Require a state to operate for at least one year, including its open enrollment period, an SBM-FP prior to transitioning to operating an SBM.
- Require an SBM to operate a centralized eligibility and enrollment platform on the state marketplace's website, which would allow for the submission of the single, streamlined application for enrollment in a QHP and insurance affordability programs, i.e. premium tax credit (APTC) and cost-sharing reduction (CSR), by consumers through the state marketplace's website.
- Require all marketplace call centers to provide consumer access to a live call center representative during a marketplace's published hours of operation, and to require call center representatives to be able to assist consumers with tasks and information related to QHP enrollment and eligibility for APTC and CSR.
- Require SBMs to provide an annual open enrollment period that starts on November 1 and ends no earlier than January 15 (it can be extended past January 15).
- Extend certain existing CMS standards for FFMs and SBM-FPs that apply to web-brokers and direct enrollment (DE) entities assisting consumers on those marketplaces to also apply to web-brokers and DE entities assisting consumers on SBMs.
- Require that HealthCare.gov changes be reflected and prominently displayed on DE entity non-marketplace websites in FFM and SBM-FP states within a specific notice period set by CMS unless CMS approves a deviation request. Also require that SBM website changes be reflected and prominently displayed on DE entity non-marketplace websites in SBM states within a specific notice period set by the SBM unless the SBM approves a deviation request.

In addition to our support for the proposals above, we offer the following recommendations:

- CMS should establish minimum standards for call center wait times, which should also include protections for consumers who require assistance in a language other than English.
- CMS should make publicly available the call center performance data it collects from marketplaces and gathers from CMS's monitoring of call center operations.

- We suggest that CMS publicly post a state’s Blueprint application within 30 days of receipt (instead of the proposed 90 days), and also require a state to provide a formal notice and comment period to the public.
- With regard to the proposed requirement for DE entities to reflect Healthcare.gov changes on their non-marketplace websites, we are concerned that the deviation request process could be misused to circumvent federal policy. We recommend that CMS clarify that deviations may be granted only upon a showing of special need, that any approved deviation is subject to regular reassessment, and that CMS may require additional materials be submitted on an ongoing basis to determine whether a deviation remains justified.

Essential Health Benefits (EHB) and Benchmark Plans

AKF supports the proposals that aim to improve, and reduce the burden of, the EHB-benchmark plan update process. Specifically, we support the proposals that would consolidate the options for states to change EHB-benchmark plans; remove the generosity standard and revise the typicality standard in assessing the scope of benefits standard; and remove the requirement for states to submit a formulary drug list as part of their documentation to change EHB-benchmark plans unless the state changes its prescription drug EHBs.

AKF strongly supports the proposal to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB, which would allow states to add routine adult dental services as an EHB by updating their EHB-benchmark plans. Proper oral health is important for everyone, but especially for people living with kidney disease. Good oral health is critical to be able to receive a kidney transplant and to have successful kidney transplant surgery. Research has shown that oral health is a key factor in the health outcomes of people with ESRD and receiving dialysis.^{1,2} Therefore, AKF fully supports policy changes that can expand access to upstream, routine dental services that help improve adult oral health and overall health outcomes, which could also help reduce health disparities and advance health equity.

We also support CMS’s proposal to transition from the current United States Pharmacopeia (USP) Medicare Model Guidelines (USP Guidelines) system to the USP Drug Classification (USP DC) system for assessing EHB standards for prescription drugs, which we recommended in CMS’s request for information on EHB. The USP DC includes more drug classes, includes drugs covered under Medicare Part B (as well as Part D), and it is updated more frequently than the USP Guidelines. We reiterate our recommendation that CMS consider implementing an annual review and update process that includes input from consumers and other stakeholders, to ensure the

¹ Costantinides F, Castronovo G, Vettori E, Frattini C, Artero ML, Bevilacqua L, Berton F, Nicolin V, Di Lenarda R. Dental Care for Patients with End-Stage Renal Disease and Undergoing Hemodialysis. *Int J Dent*. 2018 Nov 13;2018:9610892. doi: 10.1155/2018/9610892. PMID: 30538746; PMCID: PMC6258100

² Hiramatsu, T., Okumura, S., Iguchi, D. et al. Higher dental care is positively associated with key prognosis factors in peritoneal dialysis patients: findings from a retrospective study. *Ren Replace Ther* 8, 6 (2022). <https://doi.org/10.1186/s41100-021-00389-x>

USP DC is staying current with the prescription drug landscape. Additionally, we recommend that the change to the USP DC should be paired with changing the minimum drug coverage requirements to require a minimum of two drugs per class and all or substantially all drugs in the six protected classes that are in Part D (anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, immunosuppressants).

Standardized and Non-Standardized Plan Options

AKF continues to support CMS's policy requiring insurers to offer standardized plan options on FFMs and SBM-FPs. Requiring standardized plan options improve affordability by providing greater access to pre-deductible coverage and requiring copays instead of coinsurance for certain services. People with chronic conditions such as chronic kidney disease, who often also have other comorbidities, have greater health needs. Using copays instead of coinsurance for certain provider visits in standardized plans provide improved cost predictability for consumers when choosing a plan. Because kidney disease disproportionately affects communities of color and other underserved populations, standardized plan options also help address health disparities by providing another way to lower cost barriers for needed services and treatments for kidney disease and other comorbidities. Standardized plans also improve and simplify the plan shopping experience by making it easier to draw meaningful comparisons between plans.

While most SBMs already require participating insurers to offer standardized plans, we recommend that the standardized plan requirements in FFMs and SBM-FPs be applied to all SBMs. This would ensure that all consumers have access to standardized plans, no matter the type of marketplace their state uses. We are not suggesting that SBMs have to adopt the exact same approach for standardized plans that CMS has established for FFMs and SBM-FPs, but they should be required to meet a federal minimum standard.

We support CMS's requirements that limit the number of non-standardized plans that insurers can offer, which for 2025 and beyond is two plans per service area in each combination of the following categories: product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision coverage. We believe this is a reasonable solution to the problem of plan choice overload, which can lead to poor enrollment decisions or forgoing enrollment due to the complexity of deciphering health insurance information. Several states already limit the number of non-standard plan offerings, and there has been no indication that it has led to reduced competition, innovation, or insurer participation. Limiting the number of non-standard plans offerings will make it easier for consumers to differentiate between their plan options and will encourage insurers to offer truly innovative products that meet the health care needs of the consumer.

CMS proposes an exceptions process to the limitation on the number of non-standardized plan options that issuers can offer, with the aim of promoting consumer access to plans with design features that facilitate the treatment of chronic and high-cost conditions, while continuing to reduce the risk of plan choice overload. Under this proposal, issuers would be permitted to offer

additional non-standardized plan options beyond the two-plan limit for 2025 and subsequent years if they demonstrate that these additional plans have reduced cost sharing of 25 percent or more for benefits pertaining to the treatment of chronic and high-cost conditions, relative to an issuer's other non-standardized plan offerings in the same product network type, metal level, and service area. Under this proposal, issuers would not be limited in the number of exceptions permitted per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, so long as the required criteria are met.

AKF appreciates CMS's commitment to ensuring consumers have access to affordable, quality marketplace coverage that works best for their health care needs. We agree that CMS's proposal does have the potential to encourage innovative plan designs for people with high-cost chronic conditions such as kidney disease and its leading cause, diabetes, while also mitigating plan choice overload. However, we do not think CMS should finalize this proposal at this time. We think more time should be given to allow the newly established requirements on standardized and non-standardized plans to play out, and to see how those requirements impact plan offerings that help lower costs and improve care for people with chronic conditions.

Issuer User Fee Rates for the 2025 Benefit Year

CMS proposes QHP issuer user fee rates for the 2025 plan year of 2.2% of total monthly premiums for FFMs and 1.8% for SBM-FPs. These rates would be a continuation of the fee rates in effect in 2024. We appreciate CMS's commitment to ensuring the issuer user fee is adequate to sustain essential marketplace-related activities, such as consumer information and outreach programs, and we appreciate CMS's increased spending on these activities in recent years following several years of diminished funding. However, we recommend that CMS consider further investment in essential marketplace functions and suggest user fee levels be set at the higher levels that were implemented before 2022.

Thank you for the opportunity to provide comments on this proposed rule.

Sincerely,



Holly Bode
Vice President of Government Affairs