January 8, 2024

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Subject: 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) (RIN 0938-AV22)

Dear Secretary Becerra,

Covered California is pleased to submit the following comments in response to the U.S. Department of Health and Human Services (HHS) proposed rule, the Notice of Benefit and Payment Parameters for 2025.

With over 1.6 million Californians enrolled in coverage, Covered California is the largest State-based Marketplace (SBM) where consumers can purchase affordable, high-quality health coverage. We make these comments based on our experience as a marketplace that has successfully expanded coverage, offering consumers both stability and choice through competing health plans. Our comments are also based on our experience and analysis of what efforts are necessary to uphold the integrity of the Affordable Care Act (ACA) and its goal to provide access to needed health coverage to individuals across the nation.

We would like to first thank HHS for its partnership and leadership in furthering the goals of the ACA and the critical role marketplaces play in ensuring access to quality, affordable coverage. More Americans are enrolled in marketplace coverage than ever before, demonstrating both the importance of marketplace coverage and the impact of the record affordability made available by the American Rescue Plan. Since implementation, SBMs have led the way in providing nimble, innovative platforms that deliver exceptional customer service while connecting our residents to quality, comprehensive health insurance. We appreciate HHS's recognition of the elements key to this success, many of which are reinforced through this proposed rule. As we applaud much of the proposed rule and its over-arching goals for marketplaces, we also share the below comments and concerns related to specific provisions.

Minimum Quantitative Network Adequacy Standards for State Exchanges
HHS proposes that, starting January 1, 2025, both SBMs and SBMs on the Federal Platform (SBM-FPs) establish time and distance standards for qualified health plans (QHPs) that are at least as stringent with those in the Federally-facilitated Marketplace (FFM). HHS further proposes that SBMs and SBM-FPs conduct, prior to QHP certification, quantitative network adequacy reviews while allowing for flexibilities for QHP issuers that fall below standards. Additionally, all QHP issuers seeking QHP certification must provide information on whether their network providers offer telehealth services. HHS also proposes an exception process for SBMs and SBM-FPs that use alternative quantitative network adequacy standards when the alternative affords provider access as great as that ensured by FFM standards.

Covered California applauds HHS's commitment to ensuring that enrollees are afforded meaningful choice and receive timely access to care without facing undue limitations or challenges. We share the belief that all health plans have an obligation to offer sufficient choice and access, and should therefore be subject to robust network adequacy review. California's two state insurance regulators, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), conduct extensive provider network analysis and compliance oversight for health plans across the state, both on- and off-exchange. Covered California partners closely with these regulators during the QHP certification process to ensure our QHPs meet these and other regulatory standards.

To avoid potentially duplicative work between state insurance regulators and the marketplaces, and to avoid creating separate, competing network adequacy standards within states that have existing state-specific quantitative standards, Covered California seeks clarification from HHS that marketplaces retain appropriate flexibility in how a state reviews and regulates network adequacy standards.

Avoiding Bifurcation in Network Adequacy Reviews by Leveraging Regulator Expertise
Working closely with the DMHC and CDI during the QHP certification process, Covered California requires network approval from the DMHC or CDI before a QHP can be certified. Recognizing the potential inefficiencies of a bifurcated network review process in California and acknowledging the established role and expertise of state regulators in ensuring network adequacy during the QHP certification process, Covered California requests that HHS permit SBMs and SBM-FPs to continue leveraging the expertise of their respective state regulators to conduct network adequacy reviews, especially where state regulators already perform effective oversight.

Flexibility to Utilize Alternative Methodologies to Measure Geographic Access
Covered California further appreciates and supports HHS's proposal to grant SBMs and SBM-FPs an exemption from FFM standards, contingent on demonstrating comparable access with alternative quantitative standards. To account for state-specific differences, we urge HHS to exercise maximum flexibility in approving alternative methodologies that still impose rigorous standards.

Given California's unique and diverse county landscape, Covered California underscores the need for a tailored and nuanced approach to network adequacy standards and review. The state's unique geography includes densely populated urban areas and expansive rural regions within individual counties, presenting a challenge under the proposed HHS standards, which prescribe a time and distance standard per county based on population density. Recognizing the complexity of California's geography, some California state quantitative standards use county designations analogous to FFM standards but further divide counties into a bifurcated review when appropriate to better meet the state's landscape, while some California state quantitative standards apply statewide without relying on county designations.

To allow for a more contextually relevant approach to meet the shared goal of ensuring adequate access to care, Covered California advocates for a broader and more robust exemption process in HHS approval of state alternatives, including exemptions where SBMs and SBM-FPs use alternative methodologies that do not rely on HHS's county designations, and allowing states to apply only distance rather than driving time measurement. If QHP issuers in California are required to apply HHS's county-wide standards, Covered California anticipates receiving an excessive and unnecessary number of individual exception requests from QHP issuers with justifications for an alternative review, to accommodate the diverse nature of expansive counties in California.

If HHS moves forward with the framework outlined in the proposed rule, we seek clarity from HHS on the procedure and timeframe for exemption request submissions. Specifically, (1) whether such requests should come from marketplaces or from state regulators, (2) whether states may seek further exemptions in future plan years as states update their network adequacy standards, (3) what factors HHS will consider when evaluating an exemption request, and (4) the timeline for requesting and receiving an exemption. Additionally, to avoid disruptions to the delivery of health care to SBM enrollees, Covered California requests flexibility to allow states to submit renewed exemption requests as state network adequacy laws change. Covered California also requests the rule provide adequate time for requesting and receiving approval of exemptions prior to implementation, to provide marketplace participants with sufficient notice of the requirements for the subsequent plan year.

Failure to Grant State Exemptions May Negatively Impact the Market

If HHS does not exercise flexibility in granting exemptions, and imposes the proposed network adequacy standards on states like California that have existing rigorous standards, Covered California anticipates significant negative impacts to the California health insurance market. Without an exemption in place, QHP issuers that also sell coverage outside of the marketplace in California would be subject to two separate network adequacy standards. QHP issuers would have to design separate products and networks based on federal standards for their QHPs that would differ from off-exchange plans subject to state standards.

Imposing separate network adequacy standards on QHPs in this manner could encourage QHP issuers to stop participating in the marketplace, or otherwise increase their off-exchange plans that are not subject to marketplace protections. This risk is especially high in the small group market, where the increased burden of designing a separate network for a relatively small number of QHPs may not be justified.

Covered California is additionally concerned that imposing two separate network adequacy standards may cause consumer confusion. Enrollees may be subject to different protections depending on whether they are enrolled in a QHP or in individual or small group coverage outside of the marketplace. Exercising flexibility in granting exemptions for states with existing network adequacy standards would alleviate these concerns.

Delayed Implementation Needed
The proposed January 1, 2025, effective date for implementation in plan year 2025 poses practical challenges for California. For example, the DMHC provides notice of the network adequacy standards and reporting requirements to applicants approximately one year prior to the upcoming plan year. This provides applicants with sufficient time to submit their networks for network adequacy review by the March prior to the upcoming plan year. The DMHC plans to issue guidance to issuers in January 2024 for plan year 2025 regulatory submissions, with filings expected in March of 2024. The finalization of HHS rules may not align with this process, resulting in a timing misalignment for 2025.

Given these challenges, Covered California requests the rules become effective one-year prior to the implementing plan year, such that an effective date of January 1, 2025 would correspond to implementation in plan year 2026. This would permit Covered California and state regulators to notice the new requirements and conduct network adequacy review during 2025, for approval to operate in the SBM for plan year 2026.

However, even a plan year 2026 implementation poses several feasibility challenges. The proposed network adequacy standards will require Covered California, in collaboration with the state regulators, to work diligently to make several significant changes throughout the period leading up to the implementing plan year. To minimize disruption to the marketplace, required changes are expected to include the following actions:

1. Request and receive exemptions from HHS for qualifying state standards;

2. Update network adequacy review tools and standards based on approved exemptions, and where not approved, update network adequacy review tools to accommodate the HHS standards;

3. Notice the final network adequacy standards to QHP issuers approximately 12 months in advance of the plan year to enable plan applicants to make adjustments to their networks as necessary to meet those requirements and to submit documentation of their networks to Covered California and the state regulator for certification and regulatory approval by the March prior to the plan year;

4. Complete a network adequacy review of all plan applicants 4-6 months in advance of the plan year in order to provide the public appropriate notice of approved QHPs. Further, the network review process in the first year of implementation will be significantly prolonged if QHP issuers that currently participate in Covered California must undergo a new network review under the proposed requirements.

While still considered an ambitious timeline given these required actions, a more feasible approach would be to allow states to postpone the effective date to January 1, 2026, for implementation in plan year 2027. This aligns better with the practicalities of the QHP certification process and allows for states to request and receive approval for exemptions to implement state quantitative standards. It would help alleviate potential disruption to enrollees in California's SBM by providing sufficient time for coordination and compliance, to manage implementation challenges, and to evaluate exemption requests and justifications.

Essential Health Benefit (EHB) Benchmark Plan Framework Changes
HHS proposes simplifying the process for updating state EHB benchmark plans, streamlining state-mandated benefits and defrayal rules, and permitting the inclusion of non-pediatric dental services as an EHB if they are part of a state's EHB-benchmark plan.

Covered California appreciates and values the proposed state flexibility within the EHB framework. In addition to promoting efficiency, the proposal would allow states to tailor their benchmark plans to meet the specific needs of individuals in their respective states.

Minimum Standards for Various SBM Operations
HHS's proposed minimum standards for SBM operations, including live assistance during business hours, a centralized eligibility and enrollment platform, and standardized consumer information for web brokers and direct enrollment entities, directly align with the core principles of the ACA. These standards reflect the essential expectations of what a Marketplace should embody and how it should function under the ACA, ultimately enhancing the consumer experience.

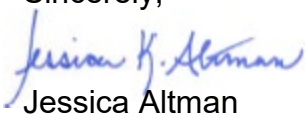
The ACA created health insurance marketplaces to streamline the shopping experience for consumers and small businesses, allowing easy comparison of plan options based on price, benefits, services, and quality. HHS's proposals, including the requirement for a centralized eligibility platform and the standardization of consumer information

provided by web brokers and direct enrollment entities, will further strengthen these critical consumer protections. This will ensure a unified platform for shopping, applying, and enrolling in QHPs with premium tax credits and cost-sharing reductions, eliminating barriers for consumers to access or transition between health coverage options.

HHS's proposal to require live assistance during business hours will also ensure a necessary level of customer service. To underscore the importance of this proposal, we draw attention to notable achievements of Covered California's Service Center in effectively delivering comprehensive pre-and post-enrollment consumer education and support. Specifically, from January 2023 to December 2023 Covered California's Service Center handled over 2 million calls with an average speed to answer of 2:49 minutes and an impressive 96.5% customer satisfaction score. These achievements exemplify the positive impact of live assistance, reinforcing the proposal's potential to continue to enhance the overall consumer experience within SBMs.

We appreciate your consideration of our comments. We look forward to continuing our partnership with you to make the ACA work as effectively as possible and build on its foundation as we work to ensure that all Americans have access to affordable health coverage. If you have any questions or would like more information, please feel free to contact me.

Sincerely,



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