Consumers for Affordable Health Care
Advocating the right to quality, affordable health care for all Mainers.

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Administrator
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7500 Security Boulevard
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Submitted electronically via www.regulations.gov

Re: CMS-9895-P: 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

Consumers for Affordable Healthcare respectfully submits the following comments in response to the proposed regulations released November 24, 2023 regarding the Notice of Benefit and Payment Parameters for 2025.

Consumers for Affordable Health Care has worked since our founding in 1988 to ensure that all people in Maine have access to quality, affordable health care. Our mission is to advocate for Maine people to be heard, respected, and well-served in a health system that provides coverage, access and quality, affordable care to all. As designated by Maine's Attorney General, CAHC serves as Maine's Consumer Assistance Program for health insurance and as such, we operate a toll-free confidential HelpLine staffed by Certified Application Counselors with expertise in private and public health insurance coverage programs. We answer questions about eligibility, help people apply for and enroll in health coverage, including private Marketplace health plans, and assist with other issues using insurance and accessing care, including helping people file complaints and appeal coverage denials. We also serve as the Ombudsman program for Maine's Medicaid program, MaineCare, and help people with applying for and navigating the enrollment process for MaineCare coverage. It is with this experience in helping Mainers apply for and navigating health care and coverage systems, including health plans through the Marketplace, that we offer the following comments on the proposed Benefit and Payment Parameters for 2025.

A. 31 CFR Part 33 and 45 CFR Part 155 – Section 1332 Waivers

We support the proposed changes to Section 1332 waiver processes allowing states the opportunity to hold post-award forums and public hearings virtually and through digital platforms, including the clarification that a hybrid (e.g., simultaneous virtual and in-person) hearing or forum does not meet the existing requirement to hold at least two such events in separate locations. We agree with CMS that such flexibility has the potential to allow for greater public participation in such events and expand the scope of input from impacted community members, for whom transportation, work schedules, and child care can be significant barriers to participation. In Maine, we have seen greater and more diverse public participation during annual Office of Affordable Healthcare hearings and public hearings on bills in an array of committees due to the availability of virtual participation. We have been able to assist more consumers testifying virtually, since people do not have to take extra time to travel to the capital, which may be multiple hours away, or take off an entire day of work in order to be physically present. This allows for greater engagement from those who may not have the time or money to travel on weekdays, allowing for a more diverse and representative showing of stakeholders across our state.

We further agree with CMS that virtual or hybrid hearings and forums can pose additional challenges for complying with federal civil rights protections and requirements for accessibility for people who are blind, deaf, hearing impaired, or people for whom English is not their primary language. As such, we encourage CMS to issue additional sub-regulatory guidance to state officials clarifying these requirements and providing examples of compliance strategies.

B. 42 CFR Parts 435 and 600 – Medicaid Eligibility for the States, District of Columbia, the Northern Mariana Islands and American Samoa, and Administrative Practice and Procedure, Health Care, Health insurance, Intergovernmental Relations, Penalties, Reporting and Recordkeeping Requirements

We support the proposed changes to allow states to implement a less restrictive Medicaid income eligibility methodology for specific non-MAGI populations and tailor income and/or resource disregards for discrete subpopulations in the same eligibility group. As CMS notes, this approach has the potential to stabilize coverage for populations for whom small changes in income or assets might otherwise interrupt access to essential services like long-term services and supports or home and community-based services.

However, we believe additional guidance regarding the eligibility criteria and application process is essential to minimizing confusion within state Medicaid agencies, health plans, and navigator programs that could result in inadvertent exclusions or barriers to enrollment. We encourage CMS to require that state plan amendments proposing changes to income and/or resource disregards for discrete subpopulations must include clear plans to educate enrollees,

beneficiaries, state staff, health plans, and navigators about the proposed changes. CMS should also offer technical assistance to states developing such communication plans to encourage and support the development of FAQs, online resources, outreach programs, and training resources that will inform affected parties of the shifts in eligibility criteria. Additionally, CMS should continue to dedicate additional resources to navigator programs and other entities offering consumer assistance or enrollment support to help beneficiaries understand and successfully navigate any changes. Additional funding could be used to increase capacity among existing assisters, as well as encourage additional community-based organizations to provide enrollment assistance, including those serving rural areas, immigrant communities, and other populations that face increased barriers to enrollment.

While we agree that states are likely to utilize these new flexibilities to expand eligibility rather than restrict access, we believe that additional safeguards are necessary to mitigate harm that would be caused by states attempting to use such flexibility to establish more restrictive eligibility criteria. We encourage CMS to prohibit state plan amendments under this new flexibility that would impose income eligibility methodologies that are more restrictive than current policy. At the very least, CMS should indicate in regulatory language that state plan amendments must include transitional periods where individuals who could lose Medicaid coverage due to changing eligibility criteria are not immediately disqualified. Such transitional periods provide individuals with the necessary time to adjust and meet the new criteria without interrupting access to care.

We also support the proposed changes to 42 CFR 600, allowing states implementing a Basic Health Plan to streamline enrollment and initiate coverage on the first day of the month following the month in which BHP eligibility is determined.

D. 45 CFR Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

Approval of a State Exchange (§ 155.105) and Election to Operate an Exchange after 2014 (§ 155.106)

We support the proposal to require that a state seeking to operate a state-based exchange must first operate a state-based exchange using the Federal platform (SBE-FP) for at least one plan year. Given the myriad state policy decisions necessary to stand up a state-based exchange, including plan certification, outreach and enrollment technology and infrastructure, and consumer assistance programming, it is safe to assume that some functions will require testing and refinement before implementation. Moreover, such a transitionary 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 potential marketplace enrollees.

We further support the proposed changes to the exchange blueprint requirements aimed at ensuring that states are making progress towards implementation of the blueprint, including live demonstrations of exchange functionality, providing accessible public notices and engagement sessions, and making public a copy of the state's exchange blueprint. Such oversight is critical to improving the enrollment experience and the proposed public engagement requirements provide much-needed transparency and opportunity for stakeholder input as states prepare for implementation.

Additional Required Benefits (§ 155.170)

We strongly support the proposed change to allow that state-mandated benefits added after December 31, 2011 to be considered Essential Health Benefits (EHBs) and therefore not subject to defrayal. In Maine, there have been several initiatives to expand mandated benefits that have either been unsuccessful or were delayed due to the possibility of a mandate defrayal. It is also a costly and time-intensive process for states to conduct mandate reviews to determine whether or not a new benefit would be subject to defrayal. Moreover, the fact that state-mandated benefits enacted after December 31, 2011 have not been able to be included in calculations for Advanced Premium Tax Credits (APTCs) or subject to consumer protections like cost-sharing limits or non-discrimination requirement has created unnecessary financial barriers and uncertainty for people enrolled in EHB coverage. This proposed change has the potential to advance health equity, especially given that many state benefit mandates enacted in recent years have been aimed at addressing the needs of historically excluded and marginalized populations, people with disabilities, people with mental health conditions and substance use disorders, and people with complex health conditions.

Consumer Assistance Tools and Programs of an Exchange (§ 155.205)

We support the proposed changes to establish additional minimum standards for exchange call center operations, and the inclusion of such additional requirements in the state exchange blueprint application. We agree that the proposed changes will improve access to consumer assistance with the QHP application process and ensure a person's geographic location does not determine the quality of support they receive. To strengthen the proposed changes, we recommend CMS provide additional guidance and support to exchange call centers in establishing dedicated language-specific phone lines and ensuring adequate staffing with qualified personnel who can best support individuals with disabilities and/or proficiency in a language other than English. Dedicated phone lines for these supports can help streamline enrollee experience and maximize enrollment.

We further encourage that rulemaking establish minimum standards for call center wait times and abandonment rates to ensure individuals have reasonable access to the supports this rule seeks to improve. Long wait times discourage people from utilizing available supports, especially among those who may have numerous questions about their application, may not

know how APTCs will lower their health insurance premiums, or individuals who cannot take time off from work but are trying to access call centers during regular business hours.

Requirement for Exchanges to Operate a Centralized Eligibility and Enrollment Platform on the Exchange's Website (§§ 155.205(b); 155.302(a)(1))

We strongly support the changes to § 155.205(b) and 155.302(a)(1), as they provide applicants with important flexibility during enrollment and take critical steps to protect QHP applicants from incorrect eligibility determinations made by non-Marketplace entities. Specifically, we appreciate the provision allowing individuals to continue the application process through the centralized eligibility and enrollment platform on an exchange's website should that individual choose to withdraw an application that began on a non-exchange website. We continue to assert that web-brokers and Direct Enrollment entities do not offer the full suite of services available on exchange websites, nor do they provide individuals with the ability to compare all health insurance plans they may be eligible for. We have received calls through our HelpLine from several people who believed they were signing up for a Marketplace QHP through an online broker but were instead enrolled in short-term, limited duration health plans, cost-sharing ministries, or other non-QHP coverage. For many of these consumers, the lack of comprehensive coverage had devastating financial consequences when they ended up needing to access care. This proposed change would create a no-wrong-door pathway for individuals to apply for QHP coverage and eliminate administrative barriers that could deter someone from abandoning an application process on a non-marketplace website that no longer meets their needs.

Moreover, we commend CMS for clarifying that only exchanges may determine QHP eligibility and related insurance affordability programs. Further, we agree that without such changes, applicants remain exposed to inaccurate eligibility determinations and significant tax liabilities related to advance premium tax credits, due to errors made by non-Marketplace entities. Such errors could lead individuals to select health insurance plans that don't meet their needs or face significant financial burdens, both of which may diminish enrollee satisfaction and thus discourage future enrollment in QHPs.

Adding and Amending Language to Ensure Web-brokers Operating in State Exchanges Meet Certain HHS Standards Applicable in the FFEs and SBE-FPs (§ 155.220)

We support the proposed alignment of consumer protections across exchanges through a nationwide standard. The proposed standard establishes a consistent, although modest, baseline while maintaining the necessary flexibility for states to strengthen consumer protections. Specifically, we appreciate the mandated disclosure concerning web-broker websites. It is crucial for individuals to be informed that these platforms are distinct from the Exchange and may not support enrollment in all QHPs for which an individual may be eligible. However, we reiterate our position that web-broker and Direct Enrollment websites are not adequate substitutes for Marketplaces maintained by the government. Direct Enrollment

websites do not contain important healthcare.gov features such as the functionality to create an account through which applicants can update their application information or apply for Medicaid coverage, if an applicant may be eligible. They also contain features that increase the risk of individuals enrolling in insurance products that do not meet their needs, lack ACA provisions such as mandated coverage of Essential Health Benefits, or do not qualify for premium tax credits. For example, although the rule proposes restrictions around incentive-based recommendations that align with federal standards, this offers limited protection because Direct Enrollment websites are only required to provide hyperlinks to marketplace plans they don't sell. This prevents individuals from reviewing and comparing full health plan information that would allow individuals to see and compare all Marketplace plans available to them in one place.

Should the proposed changes be finalized, we urge the agency to implement additional safeguards. We recommend that **web-brokers be required to: display all marketplace plan information in an impartial manner so that the displays exactly replicate those found on healthcare.gov or state-based marketplaces; screen applicants for Medicare and Medicaid; and disclose their commission amount.** Furthermore, we recommend that HHS not only limit marketing of non-QHPs "in a manner that minimizes the likelihood that consumers will be confused," but **prohibit web-brokers from marketing products that are not compliant with ACA reforms during Open Enrollment.** Such provisions promote transparency and empower individuals with clear information about the financial incentives of web-brokers assisting with health plan selections. In addition to these enhanced consumer protections, **we recommend HHS increase funding to the navigator program through 3-year grants to expand access to impartial enrollment assistance.**

Failure to Reconcile (FTR) Process (§ 155.305(f)(4))

Consumers for Affordable Health Care supports the Department's efforts to promote continuity of coverage, encourage compliance with filing and reconciling requirements, minimize the risk of large tax liabilities for Advance Premium Tax Credit (APTC) recipients and avoid situations where enrollees become uninsured when their APTC is terminated. We support the proposed change requiring all exchanges, including state exchanges, to check failure-to-reconcile status at least annually. This proactive measure, accompanied by advance notice to enrollees about the potential loss of APTC eligibility, will mitigate coverage gaps by providing enrollees with additional time to rectify outstanding issues.

The success of this change relies on exchanges sending prompt notices to enrollees that are easily understood. To promote consistency across states, we recommend regulatory language be further refined by providing easy-to-understand language that must be included in notices about APTCs, mirroring practices in other sections of this proposed rule. States should have the flexibility to expand upon such notices to reflect state requirements or local needs, provided such changes do not conflict with the finalized rule. In addition, exchanges should be required

to include taglines in these notices about the availability of no-cost translation and interpretation services, ensuring all enrollees can access information in the language they are most proficient in.

Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange (§ 155.315(e))

We support the proposed changes to §155.315(e), permitting all Marketplaces to accept applicants' attestation of incarceration status without additional electronic verification. Moreover, we appreciate the provision requiring states to seek HHS approval before commencing with a verification process that would continue to use an alternative electronic data source. These changes acknowledge the unique barriers faced by justice-involved populations and are a crucial step toward minimizing inequitable access to health insurance coverage. Specifically, racism and systemic discrimination within the criminal justice system continue to drive higher incarceration rates for Black and Hispanic people, making this policy modification particularly impactful for these communities. By minimizing enrollment barriers and reducing the administrative burden for states, the proposed rule has the potential to improve access to health care coverage while maintaining program integrity.

Initial and Annual Open Enrollment Periods (§ 155.410)

We support the proposed changes to align state marketplace open enrollment periods and require that all state marketplaces adopt an open enrollment period that begins on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15 of the applicable benefit year. We further support the allowance to extend the open enrollment period beyond January 15 of the applicable benefit year. We agree that this policy would reduce confusion among enrollees, ensure a more consistent window of opportunity for outreach and navigator support, and maximize enrollment through greater alignment with open enrollment periods for Medicare and employer-sponsored insurance.

Effective Dates of Coverage (§ 155.420(b)) and Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income at or Below 150 Percent of the Federal Poverty Level

We support the proposed changes at § 155.420 to minimize potential coverage gaps by aligning effective coverage dates across all exchanges such that people enrolling in coverage during a special enrollment period (SEP) have coverage effective on the first day of the month after they make their plan selection.

We also generally support the proposed changes to revise the parameters for the SEP for APTC-eligible individuals with a household income at or below 150 percent of the federal poverty level. We agree that the proposal to remove the limitation that this SEP only be available during periods when available APTC results in the applicable taxpayers' applicable percentage is set to

zero will better maximize access to affordable coverage, particularly for people who have had trouble enrolling during standard enrollment timelines or who are facing a coverage transition due to loss of Medicaid or CHIP coverage. However, we urge the Departments to consider broadening the income limit for this special enrollment period to better align with Medicaid and CHIP income eligibility income limits in Maine, especially as we continue eligibility redeterminations for these populations.

Establishment of Exchange Network Adequacy Standards (§ 155.1050)

We support the proposed changes to require SBMs and SBE-FPs to establish quantitative time and distance standards for all QHPs that are at least as stringent as the network adequacy standards in federally-facilitated exchanges (FFEs). We also support the proposal to require SBE-FPs to conduct quantitative network adequacy reviews as part of the plan certification process. Given the proliferation of plans with narrow networks that are insufficient to meet the needs of enrollees, particularly for mental health, behavioral health, and substance use disorder treatment services, we agree with CMS that it is necessary to subject all plans seeking certification to a quantitative analysis of provider network adequacy. We further encourage CMS in future rulemaking to similarly apply FFE requirements for appointment wait time measures to SBMs and SBE-FPs.

However, we urge CMS to reconsider the limited exception to these network adequacy requirements for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers, especially given that CMS does extend this exception to QHPs who are likely to draw from the same pool of dental providers or even contract directly with an SADP issuer to offer pediatric dental coverage – whether by requirement or by choice. Dental provider availability remains a concern, especially in rural areas and rather than extending this limited exception to SADPs in SBMs and SBE-FPs, we urge CMS to enforce dental network adequacy equally across QHPs and SADPs and further, pursue policies that aim to close gaps in access to dental providers rather than allowing insurers, regardless of type, to avoid responsibility in ensuring access to the services their members pay for.

Proposal Related to QHP Reporting on Telehealth Services

We appreciate HHS' continued efforts to understand access to telehealth services to inform future policies and believe that community voices should be centered in future policy through strategies like regional listening sessions in multiple languages, trusted community partnerships, and infusing resources into communities with limited broadband access or digital literacy.

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. There continues to be inequitable access to the technology needed to complete telehealth appointments. For example, the inequitable development of broadband

infrastructure resulted in limited access for BIPOC communities, telehealth utilization remains low in communities with higher rates of poverty, and individuals proficient in a language other than English continue to face barriers to telehealth services. Many Mainers live in communities were reliable internet is not available. The means by which health care services are delivered should be determined by patients and their providers, based on individual preference and medical need. Allowing insurers to meet network adequacy standards with telehealth services in lieu of in-person would restrict – not expand – access.

While we acknowledge efforts to align telehealth reporting standards across exchange platforms, additional refinement of reporting language would improve future policy. As stated in the proposed rule, CMS defines telehealth as professional consultations, office visits, and office psychiatry services delivered through tech-based methods, including virtual check-ins, remote evaluation of pre-recorded patient data, and inter-professional internet consultations. Existing reporting standards present three options to identify providers that offer telehealth services; however, they lack sufficient clarity to discern the telehealth services directly available to patients. For example, insurers could report that a provider does offer telehealth services by appropriately selecting "yes" from the available options, when such provider only utilizes inter-professional internet consultations. We recommend that the proposed reporting standard be amended to distinguish between inter-professional digital health services and those available to patients. We further recommend the addition of a reporting option to specify the availability of audio-only telehealth services, so future policies may appropriately address inequitable broadband access.

E. 45 CFR Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

State Selection of EHB-Benchmark Plans for Plan Years Beginning on or after January 1, 2027 (§ 156.111)

In general, we support the proposed changes to reduce the burden on states when making updates to EHB benchmark plans. The existing requirements for EHB benchmark generosity and typicality with respect to employer-sponsored coverage present significant barriers for states in expanding the scope of EHB coverage standards and evaluating benchmark options. We therefore appreciate the proposed simplification to § 156.111(a) stating that for plan years beginning in 2027, a state may change its EHB benchmark plan by selecting a set of benefits that would become the state's EHB benchmark plan.

We further support the proposed simplification of the typicality requirement allowing that a state's EHB benchmark plan would be required to provide a scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan and as or less generous than the scope of benefits in the most generous typical employer plan in the state. In addition, we agree that the proposed changes to the typicality standards largely

negate the need for a separate generosity standard at § 156.111(b)(2) and further appreciate CMS' recognition that the established upper bounds of typicality must be viewed as flexible in order to align with increases in generosity of large group employer plans in the state.

However, **we urge CMS to align the effective date of these provisions with the proposed changes to defrayal of state-mandated benefits and the elimination of the regulatory prohibition on routine adult dental services as EHB**. Allowing states to take advantage of all of these flexibilities starting with plan year 2025 will reduce confusion and ease the administrative burden of evaluating EHB benchmarks with respect to additional EHB services.

Further, we remain concerned about the inequitable access to critical services due to state level variation in EHB benchmarks, particularly for underserved and marginalized populations for whom typical employer-sponsored insurance was not designed. As such, urge HHS and CMS to strengthen federal minimum standards for EHB coverage in order to attend to longstanding gaps and inconsistencies in EHB categories such as maternity and newborn care, mental health and substance use disorder services, prescription drugs, and pediatric services, among others.

Any future iteration of the process to review and update EHB, should be regular, transparent, equitable and provide meaningful opportunities for underserved communities and their representatives to participate in the decision-making process. Congress intended the EHB standard to provide a nationwide floor for coverage with the expectation that HHS would further clarify this standard beyond the ten statutory categories. Clarifying these standards does not inherently require the elimination of the state benchmark approach but could ensure that variation in EHB benchmarks from state to state do not result in inequitable access to care.

Provision of EHB (§ 156.115)

We strongly support CMS' proposal to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an EHB. We agree with CMS' reinterpretation and more holistic view that considers all benefits typically covered by employers, whether they are embedded in medical plans or in a separate excepted benefits plan. Relatedly, we agree with CMS' assessment that routine adult dental care is a commonly covered benefit in employer sponsored insurance (ESI) arrangements and should be included per the typicality standard. Data show that, even though most people do not get dental benefits through their medical plan, the vast majority of people with dental insurance are covered by an employer-sponsored plan or similar group program. Similarly, about two-thirds of employers offer dental plans to their employees, with most of these being offered separately from a medical plan. All in all, data clearly show that dental benefits are typically covered by employers and this arrangement should be reflected in EHB standards.

We also agree that CMS' reinterpretation represents a more reasonable and less restrictive reading of the ACA, the intent of which was to ensure that the full scope of benefits typically provided by employer plans be included as EHBs to ensure that Marketplace plans align with employer-sponsored plans.

We applaud CMS' commitment to improving access to care and health equity in this proposed rule via removal of this regulatory prohibition. We believe this is particularly important given the common access and financial barriers to dental care for working age adults – dental care presents the highest financial barriers of any health care service – and especially the racial and income-based disparities in access and outcomes outlined in the proposed rule. We also believe this reinterpretation is more aligned with CMS' goal of supporting state flexibility and local leadership. Amending the regulatory framework in this way would offer greater flexibility and cause no harm to states that do not wish to make changes to their benchmark plans. This is especially true given: 1) CMS' clarification that states would need to update their benchmark plans to explicitly specify that non-pediatric dental services are being included as an EHB, even if that state's benchmark plan currently includes non-pediatric dental care as a non-EHB covered service; 2) the expectation that states weigh the advantages and challenges of adding non-pediatric dental services in determining whether to update their benchmark plan accordingly; and 3) the other simplifications to the benchmark-setting process proposed in this rule, namely the removal of the generosity standard, improvements to the typicality standard, and updates to state defrayal rules.

We further support similar changes to be made regarding routine non-pediatric eye exam services. Eye exams are crucial yearly health visits and provide opportunities to identify more than 270 systemic and chronic diseases, including diabetes, high blood pressure, autoimmune diseases, and cancers. These exams are especially valuable to adults because the risk of vision problems increases after the age of 40.

Furthermore, **we urge HHS to embed adult dental services into the ambulatory and preventive services EHB categories.** While we applaud the progress this rule represents in providing flexibility for states to offer additional coverage of adult dental services, we remain concerned about the considerable variation in EHB coverage across states and resultant inequitable access to critical dental services that results from the benchmark approach. We are concerned that relying exclusively on states to take up an optional policy could still leave many working age adults vulnerable to the gaps inherent to the current EHB standards, which leave millions of people to pay high out-of-pocket costs, seek care in emergency departments where they incur debt, or live in pain because they can't afford the care they need. Given CMS' interpretation of non-pediatric dental services as commonly included as a part of typical ESI arrangements, we believe adding adult dental benefits as a required coverage category under EHB is the logical next step.

Prescription Drug Benefits (§ 156.122) and Coverage of Prescription Drugs as EHB
We support the adoption of the USP Drug Classification (DC) to replace the USP Medicare Model Guidelines (MMG). We agree with CMS' assessment in the current rule that the USP DC has greater benefits to consumers and includes a wider range of prescription drugs, including outpatient medications. We also agree with CMS' assessment that USP DC annual updates allow for more flexibility to incorporate new drugs and remove discontinued or newly contraindicated drugs and would allow the EHB standards to more easily keep up with clinical advancements. We believe these consumer benefits outweigh any administrative burdens issuers may experience as a result of this shift.

We are also in strong support of CMS' clarification that prescription drug offerings that go beyond those covered by a state's benchmark plan are considered EHBs and are subject to related protections, including annual cost sharing limits. We believe this policy recognizes that there are multiple drugs within each classification that a plan might reasonably offer and that coverage above and beyond what is specifically outlined in the state's EHB benchmark plan allows for plans to adapt their coverage based on emerging evidence and patient need.

Finally, we have long been concerned about the significant state-by-state variation inherent to the current EHB framework's reliance on state-selected benchmarks. This approach has resulted in gaps in coverage and inequitable access to critical services, including prescription drugs and medications that are critical for treatment for people with substance use disorders. Coverage of prescription drugs varies in EHB plans from state to state and insurance plan documents aren't always clear on what's covered. We encourage CMS to further strengthen federal minimum standards for prescription drugs as well as medications for opioid disorder treatment and reversal.

Standardized Plan Options (§ 156.201)
We appreciate CMS' continued efforts to ensure the availability of standardized plan options and to require issuers to differentially display standardized plans. Such plan options are an essential tool for increasing enrollment while optimizing affordability of coverage and access to services that can address health disparities in marketplace coverage. As such, we urge CMS to continue to strive for alignment in plan offerings across state-based and federally-facilitated exchanges by requiring all issuers offering individual market plans in state exchanges without standardized plan requirements as well as in states transitioning from an FFE or SBE-FP to a state exchange to offer standardized plan options consistent with federal exchange requirements. We also urge CMS to ensure that standardized plan requirements in SBEs are at least as stringent as requirements on the FFE.

In Maine, standardized plans, called "Clear Choice" plans, are permitted to deviate from the standardized benefit package by opting to exclude pediatric dental benefits (which are embedded in the Clear Choice benefit packages) as well as by implementing tiered networks.

The purpose of standardizing benefits between plans is to simplify the plan selection experience and to allow consumers to make apples-to-apples comparisons when shopping for health plans. However, the current variation permitted between plans within a single clear choice benefit structure undermines the ability for consumers to make a true apples-to-apples comparison between plans. Furthermore, these benefit variations frequently lead to higher out-of-pocket costs for consumers. This issue is particularly relevant to plans with tiered benefit designs, which in our experiences working with patients and consumers, are particularly confusing for individuals to understand. For example, last year in Kennebec County, Maine, half of the six Silver $4,200 clear choice plans offered on the Marketplace utilize tiered networks, all of which offered different levels of cost-sharing and included cost-sharing amounts that were higher than the cost-sharing levels specified in the Silver $4,200 clear choice design developed by the Bureau of Insurance. In addition to higher deductible and copay amounts, one plan subjected a tier 2 specialist visit to a $130 copay **after** meeting a $7,000 deductible, even though this service should have had pre-deductible coverage, and a much smaller copay, based on the cost-sharing designated in the applicable Clear Choice benefit design.

2023 Tiered Clear Choice Silver $4,200 Plans Offered On-Marketplace in Kennebec County, Maine

Clear Choice Silver $4,200 Benefit Design		**Deductible** $4,200		**Max OOP** $9,100		**PCP** $50		**Specialist** $80	
Tiered Plans		**T1**	**T2**	**T1**	**T2**	**T1**	**T2**	**T1**	**T2**
CHO	Health Options Clear Choice Silver $4200 HMO Tiered NE	$4,200	$5,040*	$9,100	$9,100	$50	$70*	$80	$95*
Anthem	Anthem Clear Choice Silver X Tiered 4200	$4,200	$6,300*	$9,100	$9,100	$35	$70*	$80	$130 **after deductible***
Harvard Pilgrim	Clear Choice Maine's Choice Plus HMO Silver 4200	$4,200	$7,000*	$9,100	$9,100	$50	$80*	$80	$110*

*Cost-sharing is higher than the amount specified in the standardized Clear Choice plan design.

Tiered network designs should only be permitted in standardized plans if the tier that provides the lowest level of coverage under the plan utilizes the standardized cost-sharing structure for that particular plan design. We do not object to carriers attempting to steer consumers to high-value providers by offering a preferred network with reduced cost-sharing amounts. However, any reduction in cost-sharing should be a reduction from whatever the designated cost-sharing amount for that particular service would be under the standardized benefit design. When shopping for plans, consumers should be able to enroll in a standardized Clear Choice plan with the assurance that they will not have to pay any more for a covered in-network service or prescription drug, than the cost-sharing amounts specified in the standardized/Clear Choice benefit design for that plan. The benefit structure established in a standardized benefit design should set the floor for the level of benefits offered in any standardized plan utilizing that

benefit design. Otherwise, labeling these plans as standardized is highly misleading to consumers, who may be left on the hook for medical bills that far exceed how much they expected to owe for a covered service or prescription drug.

We also urge HHS to include standardized cost-sharing for pediatric dental services in the standardized options for 2025 and beyond. This would present the greatest opportunity for children enrolled in marketplace coverage to receive the full range of EHB coverage, as standardized options have been relatively popular among marketplace consumers.

Pediatric dental coverage remains one of the more complex aspects of marketplace coverage for consumers as it may be offered separately or as part of a QHP. While CMS rulemaking to date has made improvements to transparency in plan information, it remains difficult for families to compare covered services, cost-sharing structures, and deductible applicability for pediatric dental services because QHPs do not always provide the same level of benefit information as stand-alone dental plans. Standardized options make plan selection easier for consumers and facilitate federal and state review, approval, and oversight and this should be inclusive of all EHB services. Furthermore, inclusion of pediatric dental services is unlikely to significantly increase QHP actuarial values.

Conclusion

Thank you for the opportunity to comment on this important rule. If you have further questions, please contact Kate Ende at kende@mainecahc.org or 207-480-2136**.**

Sincerely,

Consumers for Affordable Health Care