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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9895-P
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted Electronically

RE: RIN 0938-AV22; 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

The National Women's Law Center ("the Law Center") appreciates the opportunity to comment on the Notice of Benefit and Payment Parameters for 2025.[1] Since 1972, the Law Center has fought for gender justice in the courts, in public policy, and in our society. It has worked to protect and advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and intersecting forms of discrimination. Through our work to develop and implement the Affordable Care Act, we have seen the impact it has had on women's health and access to care, and we firmly believe that robust enforcement of its provisions will continue to improve their wellbeing and lives.

We support many aspects of the rule and offer suggestions to strengthen it. Among other recommendations, we urge the Department of Health and Human Services ("the Department") to adopt the following policies:

- Establish permanent Special Enrollment Periods for individuals with incomes up to 250% of the Federal Poverty Level and for pregnant people;
- Apply standards regulating web-brokers and direct enrollment platforms to state Exchanges;
- Require states to offer standardized plans;

[1] 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, 88 Fed. Reg. 82510 (proposed Nov. 24, 2023) (to be codified at 42 C.F.R. pts. 435; 45 C.F.R. pts. 153, 155, and 156) (hereinafter "Proposed Rule").

- Require all Exchanges to provide an annual notice for consumers who have not reconciled their advance premium tax credits;
- Require all Exchanges to accept enrollees' self-attestation of their incarceration status;
- Strengthen Essential Health Benefit coverage by setting national standards for each category, clarifying that benefits covered in the state's benchmark plan are not considered "in addition to" EHB, and revising the process for updating benchmark plans;
- Extend time and distance network adequacy standards to state Exchanges and establish a range of additional standards across all Exchanges.

I. Facilitating Enrollment

a. State Exchange Enrollment Periods

We support setting minimum enrollment period dates for state Exchanges that align with HealthCare.gov, beginning on November 1 and ending no earlier than January 15. While some states have sought to impose shorter timeframes, an adequate open enrollment period is necessary so that consumers can fully evaluate their options, consult Navigators and assisters, benefit from outreach efforts, and make informed decisions about their coverage. This is particularly important for people who might need additional time to choose a plan, including people with complex health needs and those who may face barriers related to disability, language, health literacy, and limited resources. It also offers consumers who are only notified of plan cost increases in January more time to consider their coverage options.

For future plan years, we encourage the Department to require all Exchanges to extend their open enrollment period to January 31. A more generous open enrollment period will continue to increase enrollment rates, as well as provide those who learn of cost increases in January more adequate time to respond accordingly. Extending the open enrollment period until the close of the month would allow for easier outreach and communication than a middle-of-the-month end date—particularly a date that frequently overlaps with a federal holiday—thereby reducing confusion about the duration of the open enrollment period.

b. Extending Special Enrollment Periods for Individuals with Low Incomes

We support the proposal to make the special enrollment period (SEP) for people with low incomes permanent. The existing SEP, targeted to individuals eligible for advance premium tax credits (APTC) with a household income at or below 150% of the Federal Poverty Level (FPL), has given consumers more opportunities to enroll in free or low-cost coverage. As the Department observes, the implementation of this SEP was followed by an increase in the proportion of Exchange enrollees with incomes at or below 150% FPL. However, the option for this SEP will expire at the end of 2025 due to the limitation that this SEP is only in place when APTC benefits are available such that the enrollee's premium contribution is set to zero.

Removing the requirement that the SEP must be concurrent with the subsidy enhancements will allow people with low incomes to continue to benefit from expanded enrollment opportunities. We recommend, however, that the Department's proposed policy go further. First, we urge it to

expand eligibility to those earning up to 250% FPL, as many people between 150% and 250% lack access to affordable insurance and face barriers to enrollment similar to those below 150% FPL. Second, we encourage the Department to make this expansion mandatory for state Exchanges rather than elective.

Strengthening the proposed SEP in this manner may help reduce the number of uninsured people, which included 11.3 million women and girls in 2022.[2] It may also help address significant racial disparities in uninsurance rates: An analysis of the nonelderly population in 2022 found that while 6.6% of white individuals were uninsured, the rate was substantially higher among those who were Native (19%), Latine (18%), Native Hawai'ians or Pacific Islander (13%), or Black (10%).[3] A Law Center analysis of women and girls similarly found that Latinas were over three times more likely than white, non-Hispanic women and girls to be uninsured in 2022, with Black and Asian women and girls also facing high rates of uninsurance.[4] These broader racial disparities hold true for women living between 151% and 250% FPL, who would benefit from a more expansive SEP: In 2022, 10% of women in this range were uninsured, with especially high rates among Native women (19%) and Latinas (18%).[5]

Data from previous special enrollment periods indicates that expanding the low-income SEP would not trigger significant adverse selection. An analysis of pandemic-related SEPs found that they in fact led to favorable selection: States that adopted more lenient enrollment policies experienced an improvement in their risk pools at almost double the rate of states that maintained pre-pandemic eligibility standards.[6] State experiences with low-income SEPs provide further evidence that the risk of adverse selection is low. For example, since 2014, Massachusetts has made an SEP available to certain individuals with incomes up to 300% FPL without seeing adverse selection and destabilization.[7] Instead, Massachusetts' enrollment data show a consistent pattern of growth and stability.[8] Similar trends have emerged in Minnesota and New York.[9] The data from these and other states suggest that a permanent, expansive low-income SEP would come with minimal risks while significantly improving insurance rates.

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[2] National Women's Law Center, *NWLC Resources on Poverty, Income, and Health Insurance in 2022* (Sep. 12, 2023), https://nwlc.org/resource/nwlc-resources-on-poverty-income-and-health-insurance.
[3] Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.
[4] National Women's Law Center, *supra* note 2.
[5] National Women's Law Center calculations based on 2022 American Community Survey (ACS), accessed through Steven Ruggles, Sarah Flood, Matthew Sobek, Daniel Backman, Annie Chen, Grace Cooper, Stephanie Richards, Renae Rogers, and Megan Schouweiler. IPUMS USA: Version 14.0. Minneapolis, MN: IPUMS, 2023. https://doi.org/10.18128/D010.V14.0.
[6] Mark A. Hall & Michael J. McCue, *Does Making Health Insurance Enrollment Easier Cause Adverse Selection?* (Apr. 4, 2022), https://www.commonwealthfund.org/blog/2022/does-making-health-insurance-enrollment-easier-cause-adverse-selection.
[7] Sarah Lueck, *Proposed Changes to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage* (Jun. 5, 2019), https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve.
[8] *Id*.
[9] Katie Keith, *New Special Enrollment Period for Low-Income People Could Boost Coverage* (Sep. 7, 2021), https://www.commonwealthfund.org/blog/2021/new-special-enrollment-period-low-income-people-could-boost-coverage.

c. Special Enrollment Period for Pregnant People

In addition to expanding the low-income SEP, the Department should establish an SEP triggered by pregnancy, making it a qualifying life event that allows individuals to gain coverage outside of the open enrollment period. Studies consistently demonstrate that coverage during pregnancy is strongly linked to improved health outcomes for pregnant people, and that racial disparities in coverage contribute to the starkly higher rates of pregnancy-related morbidity and mortality among Black and Native people.[10] Indeed, compared to white women, pregnancy-related mortality rates are over three and two times higher for Black and Native women respectively, a gap that has only grown in recent years.[11]

The vast majority (84%) of pregnancy-related deaths are preventable,[12] underscoring that these health outcomes can be reshaped with increased access to prenatal care, in conjunction with other systemic reforms. But the cost of pregnancy and birthing care can be prohibitive for people without coverage of these services—especially for those experiencing pregnancy-related complications, who are disproportionately Black, Native, and disabled women.[13] And since pregnancy is time-bound and frequently unplanned, and given the curtailment, inaccessibility, and illegality of abortion services in the wake of the devastating *Dobbs v. Jackson Women's Health Organization* decision, it is important that uninsured people or people without adequate pregnancy-related benefits can gain coverage outside of the open enrollment period. We therefore urge the Department to establish an SEP triggered by pregnancy and, in the interim, to clarify that states have the authority to create this SEP administratively.

d. Web-Broker and Direct Enrollment Standards

We support extending regulations related to web-brokers and direct enrollment (DE) platforms to state exchanges. These regulations should include the full range of standards that currently apply to web-brokers and DE platforms operating in the Federally Facilitated Exchanges (FFEs) and the State-Based Exchanges on the federal platform (SBE-FPs), such as requirements related to the marketing and display of qualified health plans (QHPs), website display of standardized plans, disclaimer language, information on eligibility for subsidies and financial assistance, and standards of conduct. With state Exchanges increasingly relying on web-brokers for enrollment, it is critical that consumers purchasing plans outside of the state platform have reliable, comprehensive, and unbiased information about the coverage options available to them and are protected against aggressive or misleading advertising tactics.

In the absence of clear regulations, some web-brokers have failed to present all available Marketplace plans or have not displayed them in a manner that allows people to compare plans

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[10] Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them* (Nov. 1, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them.
[11] *Id*.
[12] *Id*.
[13] *Id.*; Jessica L. Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, 4 JAMA NETWORK OPEN e213414 (Dec. 2021), https://doi.org/10.1001/jamanetworkopen.2021.38414.

based on price and quality.[14] Web brokers have sometimes also presented plans in a skewed, inaccurate, or even fraudulent manner.[15] For example, in a 2023 secret shopper study that investigated the enrollment experiences of individuals losing Medicaid coverage, web-brokers failed to inform consumers of their eligibility for $0 premium, $0 deductible Marketplace plans and often inflated the costs and risks of available plans.[16]

Because web-brokers receive far higher compensation for selling substandard, non-ACA-compliant plans than Marketplace plans, they may be incentivized to redirect consumers from Marketplace plans to coverage that does not comply with key consumer protections, like the prohibition on discrimination based on sex or preexisting conditions.[17] The harms of such practices fall heaviest on women—particularly women of color, LGBTQI+ women, and disabled women—as they are disproportionately impacted by discriminatory or harmful practices otherwise mitigated by the ACA[18] and have higher rates of preexisting conditions.[19] Strengthening standards for web-brokers operating on state Exchanges can help mitigate the harms of many of these practices.

e. Reenrollment for Individuals with Catastrophic Coverage

The Department proposes that when people enrolled in catastrophic coverage do not select a plan during open enrollment, and they are no longer eligible for catastrophic coverage or the issuer no longer offers a catastrophic plan, the Exchange must reenroll them in a comparable bronze metal level QHP, or an alternative if a bronze plan is no available. We generally support this proposal, which would help prevent gaps in coverage for individuals who rely on catastrophic plans, such as those who have lower incomes or are dealing with financial instability.[20] However, we encourage the Department to require Exchanges to screen for subsidy eligibility as part of the

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[14] Tara Straw, *"Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm* (Mar. 15, 2019), https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes.

[15] Rachel Schwab & JoAnn Volk, *Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage* (Aug. 2023), https://georgetown.app.box.com/v/the-perfect-storm-august-2023.

[16] *Id*.

[17] *See, e.g.,* U.S. House of Representative Committee on Energy and Commerce, *Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk* at 43 (Jun. 2020), https://docs.house.gov/meetings/IF/IF14/20210323/111378/HHRG-117-IF14-20210323-SD023.pdf.

[18] *Id*. at 74.

[19] Michelle Long & Alina Salganicoff, *Pre-Existing Condition Prevalence Among Women Under Age 65* (Nov. 4, 2020), https://www.kff.org/womens-health-policy/issue-brief/pre-existing-condition-prevalence-among-women-under-age-65; Latoya Hill et al., *Key Facts on Health and Health Care by Race and Ethnicity* (Jan. 26, 2022), https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity; Caroline Medina & Lindsay Mahowald, *Repealing the Affordable Care Act Would Have Devastating Impacts on LGBTQ People* (Oct. 15, 2020), https://www.americanprogress.org/article/repealing-affordable-care-act-devastating-impacts-lgbtq-people; Centers for Disease Control and Prevention, "Disability and Related Conditions," *Disability and Health Promotion* (Sep. 16, 2020), https://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html.

[20] Nambi Ndugga & Samantha Artiga, *Disparities in Health and Health Care: 5 Key Questions and Answers* (Apr. 21, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers.

reenrollment process in order to determine if an individual qualifies for a low-cost silver-level metal plan, which would offer more robust coverage than a bronze-level plan.

Additionally, we support the clarification that Exchanges may not automatically reenroll an individual with a metal-level plan into catastrophic coverage, which should be used only for limited purposes due to its narrow benefits and high deductibles.

f. Standardized Plans

The Department seeks feedback about whether it should require state Exchanges to offer standardized plans in future rulemaking. We encourage it to do so, thus extending the benefits of these plans to consumers in states that run their own Exchanges. Standardized plans make the often-complex enrollment process easier by simplifying the variation in cost-sharing and allowing people to compare a more targeted range of features, especially benefitting people who face barriers to health literacy or who have complex health needs. They also maximize access to covered services with lower cost sharing. Standardized plans have been shown to limit discriminatory benefit designs, such as the exclusion of specialists in a certain field or the adverse tiering of drugs for targeted conditions—often conditions that disproportionately affect women of color, disabled women, and LGBTQI+ people.[21]

States have also used standardized plans to promote health equity, and requiring standardized plans in all states may encourage more to adopt similar strategies. In particular, several states mandate that standardized plans minimize cost sharing for conditions that disproportionately affect people of color and other underserved communities.[22] Standardized plans in Washington, DC, for example, must waive cost sharing for services related to type 2 diabetes. In Colorado, standardized plans may not impose cost sharing on outpatient visits for mental health conditions and substance use disorders. And New York and California limit cost sharing for a range of specialty prescription drugs.[23]

In order to maximize the benefits of standardized plans in state Exchanges, we encourage the application of clear requirements comparable to those applied to FFEs. We appreciate the Department's emphasis on the need for flexibility for state Exchanges, but we encourage it to set a strong national floor to ensure that standardized plans are implemented effectively across all states, leaving the flexibility for states to build upon the minimum requirements.

g. Failure to File and Reconcile

We support the Department's proposal to require all Exchanges, including state Exchanges, to check failure-to-reconcile (FTR) status at least annually and send notices to enrollees for the first year that they have failed to reconcile their APTC, informing them of the risk of becoming ineligible for APTC if they fail to file and reconcile for a second consecutive year. Many

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[21] Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFFAIRS (Jan. 6, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160106.052546/full.
[22] Karen Pollitz et al., *Standardized Plans in the Health Care Marketplace: Changing Requirements* (May 8, 2023), https://www.kff.org/private-insurance/issue-brief/standardized-plans-in-the-health-care-marketplace-changing-requirements.
[23] *Id.*

consumers and even third-party tax preparers are unaware of the responsibility to reconcile APTC, leading some people to lose their subsidies despite their continued eligibility. Annual notices may help mitigate the risk of unwarranted denials.

The notice must be clear, accessible, and as explicit as possible about the risk of losing APTC. Many consumers find notices regarding their tax responsibilities to be difficult to understand, a common problem that may be exacerbated by barriers related to language, literacy, or disability. Some might not receive a mailed notice or receive it too late, particularly if they are experiencing housing changes or instability, and others may face challenges accessing notices sent electronically.

Exchanges can reduce the risk of some of these problems by integrating the APTC notice into the enrollment process. For example, as an addition to a standalone notice, Exchanges can create an automatic popup alert that is displayed when an applicant accesses the enrollment website, informing the applicant that they are at risk of losing their APTC in the following year if they do not address their FTR status. All formats of the notice should be accessible to people with a range of disabilities and available in the most common languages spoken in the state.

We note, however, that while required notices reduce the risk of APTC denials, they do not cure the problem entirely. In an effort to comply with restrictions on the release of tax information to individuals who are not the household tax filers, the proposed rule continues to allow notices to include "broad, general language regarding FTR" listing multiple potential reasons for why the recipient may be at risk of losing APTC.[24] Such notices are often too vague to inform individuals of their FTR status, raising serious due process questions and increasing the risk of unwarranted denials of APTC the following year. We urge the Department to pause denials of APTC until it develops a more effective and constitutionally sound procedure for notices to non-tax filers.

II. Eligibility Determinations

a. Centralized Eligibility and Enrollment Determinations

We support the requirement that Exchanges have a centralized eligibility and enrollment platform on their website. Some states have sought to eliminate this centralized platform and instead force consumers to sign up for plans and financial assistance only through brokers or private insurers. This practice could cut applicants off from trained, unbiased Navigators and comprehensive sources of information that allow them to fully assess their insurance choices. Compared to government-based platforms, brokers and private insurance companies are less incentivized to offer consumers neutral information about coverage options, and more likely to redirect them to subpar plans, including non-ACA-compliant plans—plans that, as discussed above, disproportionately harm women and other underserved populations. Unlike Navigators, brokers and private insurers may also fail to inform qualified applicants of their Medicaid eligibility.

[24] Proposed Rule, 88 Fed. Reg. at 82,571.

We also support codifying the requirement that the Exchange is the sole entity that makes eligibility determinations, regardless of whether the application is submitted through the Exchange website or a direct enrollment platform. This would ensure that state Exchanges do not delegate the responsibility to conduct eligibility determinations to third parties like web-brokers, who may impose eligibility standards that differ from those of Exchanges.

b. Incarceration Status

We agree with the Department that the current system, where Exchanges must check third-party databases to verify incarceration status, is flawed and leads to inaccurate Data Matching Issues (DMIs). These DMIs require applicants subject to incarceration DMIs to provide unnecessary and burdensome documentation to prove that they are not currently incarcerated. However, we urge the Department to revise its proposed policy of giving Exchanges the option of accepting applicants' attestation of their status without further verification. Instead, it should require them to do so.

Any benefits of electronic verification of incarceration status are far outweighed by both the costs to the state and, most importantly, the impacts on individuals whose coverage is delayed or denied. As the Department notes, the vast majority of DMIs are unwarranted: A study of incarceration DMIs found that a full 96.5% were resolved in favor of the applicant, with extenuating circumstances accounting for most of the remaining cases.[25] Resolving a DMI, however, can require extensive documentation. In some instances, these burdensome requirements can prompt applicants to drop out of the enrollment process; in others, it can cause delays in coverage, even in cases where the DMI is ultimately resolved.

Providing the requisite documentation to resolve a DMI can be difficult or even impossible for many individuals, particularly those who are formerly incarcerated. Substantiating one's incarceration status typically requires a current ID, which many formerly incarcerated people face barriers to obtaining.[26] For example, some jails or prisons confiscate IDs at the start of an individual's incarceration and either destroy them or fail to return them upon reentry.[27] Even if an ID is returned intact, it may have expired during the individual's period of incarceration.[28] Since acquiring a new ID typically requires some existing form of valid ID, some formerly incarcerated people may be left without any means of doing so.[29] Getting a new ID can also be expensive; many formerly incarcerated people therefore face financial barriers to obtaining IDs, which are compounded by the hurdles they may face to securing employment after incarceration.[30]

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[25] Proposed Rule, 88 Fed. Reg. at 82573.
[26] Movement Advancement Project, *The ID Divide: How Barriers to ID Impact Different Communities and Affect Us All* (Nov. 2022), https://www.mapresearch.org/file/MAP-Identity-Documents-report-2022.pdf.
[27] Movement Advancement Project, *Identity Documents & Formerly Incarcerated People* (Nov. 2022), https://www.mapresearch.org/file/ID-info-formerly-incarcerated-people.pdf.
[28] *Id*.
[29] *Id*.
[30] *Id*.

Due to disparities in incarceration and interactions with the criminal legal system, incarceration DMIs disproportionately impact Black and Latine people, disabled people, LGBTQI+ people and people with low incomes.[31] Individuals from these communities are also more likely to face barriers to employment after incarceration and to obtaining government IDs and other documentation, further complicating the barriers they may face to resolving DMIs.[32]

The potential delay or denial of coverage is particularly troubling given the health disparities that formerly incarcerated people already experience. People who are formerly incarcerated are more likely than those without a history of incarceration to have a range of health conditions, including high blood pressure, cancer, arthritis, mental health conditions, and infectious diseases.[33] Women with a history of incarceration have particularly pronounced health disparities compared to formerly incarcerated men: They are more likely to experience conditions such as tuberculosis, hepatitis, high blood pressure, HIV, and HPV, and they are more likely to have experienced past trauma or abuse that exacerbates mental and physical health conditions.[34] LGBTQI+ people who were formerly incarcerated are also more likely to experience a range of health disparities, often worsened by harms they many face during their incarceration, like pervasive denials of medical care, sexual and physical victimization, and traumatic solitary confinement.[35] These disparities make it all the more necessary that formerly incarcerated people are able to get access to coverage, as one critical component of health justice for people with a history of incarceration.

Therefore, given the harms of incarceration DMIs and their limited benefits, the Department should make it mandatory rather than optional for states to accept applicants' attestation of their incarceration status. If the Department proceeds with its policy as proposed, where it would allow Exchanges to use an electronic data source subject to its approval, it should ensure that its evaluation of the data source prioritizes minimizing burdens on applicants, particularly those who face the greatest health disparities and barriers to resolving DMIs.

c. Resource and Income Disregards in Medicaid Programs

The Department proposes to give states the flexibility to modify non-MAGI eligibility by allowing them to adopt resource and income disregards for discrete subpopulations. We are concerned that the proposed rule does not adequately assess the risks and benefits of such a

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[31] *See, e.g.,* Nazgol Ghandnoosh, *One in Five: Ending Racial Inequity in Incarceration* (Oct. 11, 2023), https://www.sentencingproject.org/reports/one-in-five-ending-racial-inequity-in-incarceration; Ashley Nellis, *The Color of Justice: Racial and Ethnic Disparity in State Prisons* (Oct. 13, 2021), https://www.sentencingproject.org/reports/the-color-of-justice-racial-and-ethnic-disparity-in-state-prisons-the-sentencing-project; Laurin Bixby et al., *The Links Between Disability, Incarceration, and Social Exclusion*, 41 HEALTH AFFAIRS (Oct. 2022), doi.org/10.1377/hlthaff.2022.00495; Nazgol Ghandnoosh & Emma Stammen, *Incarcerated LGBTQ+ Adults and Youth* (Jun. 2022), https://www.sentencingproject.org/policy-brief/incarcerated-lgbtq-adults-and-youth.

[32] Movement Advancement Project, *supra* note 26.

[33] Department of Health and Human Services & Office of Disease Prevention and Health Promotion, "Incarceration," *Healthy People 2030* (last accessed Dec. 19, 2023), https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration.

[34] *Id*.

[35] *See generally* Valerio Baćak et al., *Incarceration as a Health Determinant for Sexual Orientation and Gender Minority Persons*, 108 AMERICAN JOURNAL OF PUBLIC HEALTH 994 (Aug. 2018), https://doi.org/10.2105/AJPH.2018.304500.

policy, its statutory basis, and mechanisms for protecting against unintended consequences. For example, in the absence of guardrails, states may be incentivized to reduce the scope of existing categorical disregards and replace them with a patchwork of disregards applying to a more limited collection of subgroups. We encourage the Department to reconsider its proposal. If it proposes a revised version in a future rulemaking, it should incorporate guardrails that would ensure states use this flexibility to build upon rather than weaken their existing eligibility standards.

III. Essential Health Benefits

a. Federal Minimum Standards for Coverage

We appreciate the Department's efforts to improve coverage of Essential Health Benefits (EHBs). Building on existing EHB coverage is much needed, as benchmark plans continue to vary widely across states. Many exclude critical services, rely on outdated medical evidence, or are insufficient to meet the needs of underserved patients. As a result, some people with benchmark-based plans contend with limited coverage, unaffordable costs, and other barriers to care.

For example, while EHB standards require coverage of pregnancy and newborn care in general, there are significant differences in state benchmark plans' approach to these services. A Center for American Progress study of EHB plans found that although some states offer comprehensive coverage of a range of services, many benchmark plans have harmful restrictions or provide coverage that falls short of current clinical recommendations. For example, some benchmark plans cover only one or two ultrasounds, restrict coverage of midwives or doulas, or exclude coverage of non-manual breast pumps.[36] These deficiencies persist even though robust coverage of pregnancy and postpartum care is necessary for reducing preventable morbidity and mortality and narrowing the disparities that particularly harm Black and Native women.

Benchmark plans also vary greatly across other EHB categories, including coverage of medications for substance use disorders,[37] mental health services,[38] and rehabilitative and habilitative services like hearing aids and mobility devices.[39] These gaps have disproportionate impacts on women, particularly women of color, disabled women, and LGBTQI+ women. For example, inadequate coverage of mental health services especially impacts women: In 2022, women (50%) were significantly more likely than men (35%) to say they needed mental health

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[36] Nora Ellmann & Jamille Fields Allsbrook, *States' Essential Health Benefits Coverage Could Advance Maternal Health Equity* (Apr. 30, 2021), https://www.americanprogress.org/article/states-essential-health-benefits-coverage-advance-maternal-health-equity.

[37] Lindsey Vuolo, *The Federal Government Needs to Take Stronger Action to Prevent Discriminatory Coverage of Methadone*, HEALTH AFFAIRS (Apr. 25, 2019), https://www.healthaffairs.org/content/forefront/federal-government-needs-take-stronger-action-prevent-discriminatory-coverage-methadone.

[38] Charley E. Willison et al., *Double-Edged Sword of Federalism: Variation in Essential Health Benefits for Mental Health and Substance Use Disorder Coverage in States*, 16 HEALTH ECONOMICS, POLICY AND LAW 170 (Apr. 2021), https://doi.org/10.1017/S1744133119000306.

[39] National Health Law Program, Letter to the Honorable Xavier Becerra re: Advancing Health Equity Through Essential Health Benefits (Dec. 6, 2021), https://healthlaw.org/wp-content/uploads/2022/02/NHeLP-letter-EHB-12.6.2021-FINAL.pdf.

services in the previous two years.[40] Women experience several mental health conditions more commonly than men; depression, for example, is twice as prevalent among women as men.[41] At the same time, women, particularly women of color and disabled women, are more likely to face barriers to accessing care. In a 2023 analysis of Household Pulse Data, the National Women's Law Center found that women overall, women of color, and disabled women were more likely to say that they needed access to mental health services but did not receive them.[42] A similar pattern emerged for LGBT people, who reported a greater need for mental health services but increased barriers to accessing them.[43] One of the biggest drivers of unmet need among people seeking mental health services is insufficient coverage and the resultant cost burden, underscoring the need for improved EHB coverage in this field.[44]

While the proposed rule offers important steps towards advancing improving coverage in these and other EHB categories, it falls short of addressing the root cause of the problem: the lack of comprehensive federal minimum requirements for EHBs. The ACA calls upon the Secretary of Health and Human Services to "define the essential health benefits" and provide standards for at least the ten listed EHB categories.[45] Even though the statute made it clear that Congress intended for the Department to exercise significant authority in determining the details of each category, the Department has delegated much of that authority to the states, leaving each state to determine its own benchmark plan. The result has been a patchwork of inconsistent standards, with many plans offering inadequate coverage and failing to meet the needs of underserved people.

In accordance with its obligations under the ACA, the Department should establish minimum federal standards for each EHB category, including at least the ten categories identified in the statute. We recognize that the Department has sought to provide states with flexibility in defining benchmark plans, but states will still be able to build upon the minimum federal standards to advance health equity, innovate, and meet the specific needs of their populations. We urge the Department to work towards the adoption of federal EHB standards in the present rulemaking and in future opportunities.

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[40] Michelle Long et al., *Experiences with Health Care Access, Cost, and Coverage: Findings from the 2022 KFF Women's Health Survey* (Dec. 20, 2022), https://www.kff.org/womens-health-policy/report/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey.
[41] Debra J. Brody et al., *Prevalence of Depression Among Adults Aged 20 and Over: United States 2013–2016*, NCHS Data Brief No. 303 (Feb. 2018), https://www.cdc.gov/nchs/products/databriefs/db303.htm.
[42] Sarah Javaid, *A Mental Health Epidemic: The COVID-19 Pandemic's Effect on Anxiety and Depression Among Women and LGBT Adults* (Jun. 2023), https://nwlc.org/wp-content/uploads/2023/06/NWLC_Report_MentalHealthReport-1.pdf.
[43] *Id*.
[44] *See, e.g.,* Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* 61 (Jan. 2023), https://www.samhsa.gov/data/report/2021-nsduh-annual-national-report; Nicholas C. Coombs et al., *Barriers to Healthcare Access Among U.S. Adults with Mental Health Challenges: A Population-Based Study*, 15 SSM - POPULATION HEALTH 100847 (Jun. 2021), https://doi.org/10.1016/j.ssmph.2021.100847; Long et al., *supra* note 40.
[45] 42 U.S.C. § 18022(b)(1).

b. EHB Defrayal Policy

We support the clarification that benefits covered in the state's benchmark plan are not considered "in addition to" EHB, even if they are mandated by the state. States may be interpreting the defrayal policy such that when they mandate coverage of certain benefits, they strip those already included in the benchmark plans of their EHB protections, including nondiscrimination requirements, limitations on cost sharing, and restrictions on annual or lifetime dollar limits.

We encourage the Department to further clarify that when states pass a mandate for the purpose of compliance with federal requirements, such as parity or nondiscrimination standards, they would not need to defray the cost of the mandate. Some states have been hesitant to add coverage requirements or adjust their benchmark plans because they are concerned that they would run afoul of defrayal requirements, including when changes to the benchmark plans are necessary to cure violations of federal law. For example, concerns about defrayal have deterred some states from changing benefits to comply with the Mental Health Parity and Addiction Equity Act, Section 1557 of the ACA, and EHB nondiscrimination requirements.

c. Updates to EHB Benchmark Plans

We support consolidating the pathways through which states can update their benchmark plans, as well as removing the requirement that states submit a drug formulary when they are not requesting changes to prescription drug benefits. Streamlining the update process can encourage more states to build on their existing EHB benchmark plans and thus address emerging and unmet health needs.

We generally support revising the typicality standard and removing the generosity limit, but we urge the Department to interpret typicality as a floor rather than also imposing a ceiling. The current typicality and generosity rules significantly constrain states' ability to update their plans, particularly if the typicality standard is interpreted to require a benchmark plan to be an exact actuarial match to a typical employer plan (TEP).

The standard proposed in this rule offers some degree of improvement upon the existing policy. By establishing the least generous TEP as a minimum and the most generous TEP as the maximum, the Department would provide states with a greater range of options for meeting the typicality requirement and set a floor for coverage. In particular, we believe that giving states greater flexibility to match large group plans, which tend to be more generous than the individual and small group market, will lead more states to expand their EHB coverage. And in conjunction with removing the generosity limit, which anchored states to the scope of 2017 plans, revising the typicality standard will allow states to strengthen their benchmarks plans in areas where some employer benefits have become more expansive in recent years, such as coverage of gender-affirming care and infertility treatment.

However, we emphasize that the ACA's typicality standard should be understood as only setting a guideline for *minimum* benchmark coverage. Reading the typicality standard as setting a hard cap is contrary to the ACA's statutory language and purpose: Typical employer plans have

traditionally excluded coverage for the same services that the EHB provision was intended to expand, and using employer plans as the ceiling for coverage would perpetuate the gaps that persisted prior to the ACA. For example, NWLC research found that plans routinely excluded pregnancy-related care prior to the enactment of the ACA[46]; interpreting the typicality provision to allow benchmark plans to go no further than TEPs would undermine states' obligations to comply with the required coverage of these services. With many employer plans continuing to provide bare-bones benefits across EHB categories, using TEPs as a ceiling for coverage would limit states to matching inadequate coverage of EHBs, undermining the intent of the ACA and compromising access to care.

d. Removing Categorical Restrictions on Adding EHBs

We support allowing states to add routine adult dental services as EHBs, but we encourage the Department to also remove the restriction on adding routine adult eye exams and long-term nursing home care benefits and rescind 45 C.F.R. § 156.115(d) in its entirety.

Coverage of adult dental care is critical to improving overall health[47] and reducing disparities in access and outcomes. Black and Latine people bear a disproportionate burden of oral health disease.[48] These disparities are driven in part by lack of access to and coverage of dental care, together with factors such as racial bias in dentistry, dental deserts in predominantly Black and Latine neighborhoods,[49] and geographic disparities in access to fluoridated water and healthy foods.[50] Access to dental care is also particularly important during pregnancy, when people are more susceptible to periodontal disease and other oral health problems.[51] Poor oral health during pregnancy may in turn be associated with outcomes such as preterm birth, low birth weight, and preeclampsia.[52] Racial disparities in access to care persist among pregnant people: For example, Black women are less likely to see a dentist during pregnancy than white women, with particularly pronounced disparities for Black women without dental coverage.[53]

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[46] National Women's Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act* 11 (2012), https://nwlc.org/wp-content/uploads/2022/09/Turning-to-Fairness-Report.pdf.
[47] Max W. Seitz et al., *Current Knowledge on Correlations Between Highly Preventable Dental Conditions and Chronic Diseases: An Umbrella Review*, 16 PREVENTING CHRONIC DISEASE (Sep. 26, 2019), http://dx.doi.org/10.5888/pcd16.180641.
[48] Luisa N. Borrell & David R. Williams, *Racism and Oral Health Equity in the United States: Identifying its Effects and Providing Future Directions*, 82 JOURNAL OF PUBLIC HEALTH DENTISTRY 8 (Jan. 27, 2022), https://doi.org/10.1111/jphd.12501.
[49] *Id*.
[50] Centers for Disease Control and Prevention, *Disparities in Oral Health* (Feb. 5, 2021), https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm.
[51] Centers for Disease Control and Prevention, *Pregnancy and Oral Health* (Mar. 18, 2022), https://www.cdc.gov/oralhealth/publications/features/pregnancy-and-oral-health.html.
[52] Annie M. Vivares-Builes et al., *Gaps in Knowledge About the Association Between Maternal Periodontitis and Adverse Obstetric Outcomes: An Umbrella Review*, 18 JOURNAL OF EVIDENCE BASED DENTAL PRACTICE 1 (Mar. 2018), https://doi.org/10.1016/j.jebdp.2017.07.006; Leonie A. Daalderop et al., *Periodontal Disease and Pregnancy Outcomes: Overview of Systematic Reviews*, 3 JDR CLINICAL AND TRANSLATIONAL RESEARCH 10 (Jan. 2018), https://doi.org/10.1177/2380084417731097.
[53] Hyewon Lee et al., *Racial Disparity in Dental Care During Pregnancy: An Analysis of the Pregnancy Risk Assessment Monitoring System from 2012 to 2015*, 32 JOURNAL OF HEALTH CARE FOR THE POOR AND UNDERSERVED 2086 (Nov. 2021), https://doi.org/10.1353/hpu.2021.0184.

The Department justifies removing the restriction on adding routine adult dental care as an EHB by pointing to the increasing rate of dental coverage among employers. We emphasize, however, that if the typicality standard is understood as a floor rather than a ceiling, it is not necessary to demonstrate that TEPs are covering services as a prerequisite for allowing states to add them as EHBs. Accordingly, based on the same rationale that applies to adult dental care, states should also not be restricted from adding routine adult eye exams and long-term nursing home care benefits as EHBs.

The existing regulatory restriction on adding these services as EHBs is unwarranted and creates a barrier to more widespread and equitable access. As with adult dental care, coverage of these services is crucial for promoting overall health and reducing disparities. For example, due in part to disparities in access to ophthalmological care,[54] women carry a greater burden of eye disease,[55] and Black and Latine people are more likely to experience blindness and low vision.[56] Inadequate coverage may also contribute to the pronounced disparities Black and Latine people face in accessing quality long-term nursing home care.[57] We note that coverage of nursing home care as an EHB must be offered in accordance with other federal laws, including Section 504 of the Rehabilitation Act of 1973 as incorporated by Section 1557 of the ACA. For example, a state that includes institutional nursing home care as an EHB but excludes home- and community-based services may be in violation of Section 1557's prohibition on services that are more segregated than is appropriate for an individual's needs. We ask the Department to clarify that states that opt to include long-term nursing home care as an EHB must comply with Section 504, Section 1557, and other federal protections.

e. Prescription Drugs

We appreciate the Department's efforts to improve coverage of prescription drugs, which are inadequately covered under many EHB benchmark plans. Plans that cover an insufficient number of drugs particularly disadvantage women, who are more likely than men to take prescription medication: 63% of non-elderly women take at least one prescription medication on a regular basis, compared to 48% of men.[58] Insufficient coverage of prescription drugs also harms people with many types of disabilities and chronic conditions, who are more likely to need less commonly covered drugs. Additionally, because women, people of color, and people with certain disabilities are underrepresented in drug trials,[59] many of the more commonly covered

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[54] *See, e.g.,* Press Release, American Academy of Ophthalmology, "New Study: Racial Disparities in Glaucoma Care Persist, Regardless of Socioeconomic Status" (Nov. 4, 2023), https://www.aao.org/newsroom/news-releases/detail/new-study-racial-disparities-in-glaucoma-care.

[55] Irene O. Aninye et al., *The Role of Sex and Gender in Women's Eye Health Disparities in the United States*, 12 BIOLOGY OF SEX DIFFERENCES 57 (Oct. 20, 2021), https://doi.org/10.1186/s13293-021-00401-3.

[56] Arthur Brant et al., *United States Ophthalmic Care: Blindness and Visual Impairment in the IRIS Registry*, 130 OPHTHALMOLOGY 1121 (Nov. 2023), https://doi.org/10.1016/j.ophtha.2023.06.011.

[57] Eric Carlson & Gelila Selassie, *Racial Disparities in Nursing Facilities—and How to Address Them* (Sep. 2022), https://justiceinaging.org/wp-content/uploads/2022/09/Racial-Disparities-in-Nursing-Facilities.pdf.

[58] Long et al., *supra* note 40.

[59] *E.g.,* Alexandra Z. Sosinky, *Enrollment of Female Participants in United States Drug and Device Phase 1–3 Clinical Trials Between 2016 and 2019*, 115 CONTEMPORARY CLINICAL TRIALS 106718 (Apr. 2022), https://doi.org/10.1016/j.cct.2022.106718; Mikhaila Alegria et al., *Reporting of Participant Race, Sex, and*

drugs are less effective or appropriate for their needs, and these individuals may be particularly likely to need access to non-covered drugs.

We support the clarification that drugs covered in excess of the benchmark plan are considered EHBs, and so they are subject to protections like cost-sharing limits and the ban on annual and lifetime dollar caps. It is critical that EHB protections be extended to a plan's entire drug formulary, rather than only the medications that a plan is required to cover. When plans exclude drugs from EHB cost-sharing protections, the impact falls most heavily on people with complex health needs—disproportionately women—who may need access to less common or more expensive medications.

We also support the requirement that Pharmacy and Therapeutics committees include a consumer representative. Doing so would help committees incorporate consumer perspectives into their consideration of issues such as whether to extend coverage to new drugs or new indications. The Department should encourage committees to prioritize health equity considerations when selecting consumer representatives, such as by requiring the consumer representative to have expertise (which may include lived experience) in conditions disproportionately affecting consumers who face greater health disparities.

Finally, the Department asks whether it should consider switching from the U.S. Pharmacopeia Medicare Model Guidelines (USP MMG) to the USP Drug Classification (DC) system. We believe that neither of these models are adequate, and that the Department should instead develop its own classification standards.

Switching to the USP DC would offer some improvements: The MMG was designed for Medicare Part D beneficiaries, most of whom are aged 65 and older, and so it is inappropriate for the needs of much of the population enrolled in EHB plans. However, the USP DC uses the MMG as a baseline and perpetuates many of its inadequacies. For example, the USP DC excludes many medications and supplies critical for reproductive and sexual health, including by failing to include the full range of contraceptives. The USP does not set the standard for contraceptive coverage in EHB plans: Any plan that must comply with EHB must also comply with the ACA's Women's Preventive Services Guidelines, including by covering all contraceptives approved, granted, or cleared by the Food and Drug Administration. If the USP DC *were* to be used as a basis, it would be deeply inadequate. The USP DC has only three drug classes for contraceptives: combination oral contraceptives, progestin-only oral contraceptives, and "other" contraceptives, a catchall class that includes hormonal and copper IUDs, rings, patches, emergency contraceptives, injectable contraception, and pH modulation gel. The active ingredient in the sponge and spermicide is not included at all. The USP DC also excludes all over-the-counter drugs, and relying on it may hamper the Department's efforts to promote coverage of the recently approved progestin-only oral contraceptive (Opill) when it is accessed without a prescription. Using the USP DC as a basis for coverage could therefore create confusion regarding plans' obligations to cover the full range of contraceptives and further

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Socioeconomic Status in Randomized Clinical Trials in General Medical Journals, 2015 vs 2019, 4 JAMA NETWORK OPEN e2111516 (May 2021), https://doi.org/10.1001/jamanetworkopen.2021.11516.

entrench ACA compliance problems that have been identified by the Law Center, other advocates, and members of Congress.[60] In addition to the gaps in coverage of contraceptives, the USP DC suffers from comparable gaps in other areas, including services related to pregnancy, pediatrics, and HIV, among other types of care.

Rather than relying on either USP classification standard, the Department should develop its own classification standards to more comprehensively meet the needs of the populations that benefit from EHBs. If it does switch to the USP DC, it should take steps to mitigate its deficiencies. For example, under current regulations, benchmark plans are required to cover only one drug per USP class and category,[61] allowing many plans to exclude a range of necessary medications from coverage. The Department could instead require EHB plans to cover at least two drugs per USP class and category, as well as "all or substantially all" of the drugs in the six protected classes of drugs that have been identified as critical to vulnerable populations.[62] We encourage the Department to build on this standard, such as by adding protected classes of drugs, with a particular focus on conditions that disproportionately impact underserved communities and inclusive of drugs related to reproductive and sexual health. Additionally, we urge the Department to thoroughly enforce the requirement to cover the preventive services in § 2713 of the Public Health Service Act, including the full range of contraceptives outlined in the HRSA Women's Guidelines.

IV. Network Adequacy Standards

In order to achieve the promise of accessible, available, and timely care, the Department must apply strong national network adequacy standards to all Exchanges. Such standards are especially important given the rise of plans with narrow networks, which leave many enrollees without sufficient and reasonably accessible options for care. We therefore appreciate the steps the Department is taking to establish a national floor of network adequacy standards, and we encourage it to expand on its proposals.

We support requiring state Exchanges and SBE-FPs to implement time and distance network adequacy standards that are at least as stringent as those applying to FFEs. Time and distance standards help promote more meaningful access to care: If a plan has only providers that are at a significant distance away from an enrollee, that enrollee may in practice be unable to access those providers, especially if they face barriers such as the high cost or unavailability of transportation and caregiving services.

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[60] *See* National Women's Law Center, *Access to Birth Control Without Out-of-Pocket Costs: Improving and Expanding the Affordable Care Act's Contraceptive Coverage Requirement* (Nov. 2021), https://nwlc.org/wp-content/uploads/2021/11/final_Long_nwlc_2021_BC_AffordCareAct-003.pdf; U.S. House of Representatives Committee on Oversight and Reform, *Barriers to Birth Control: An Analysis of Contraceptive Coverage and Costs for Patients with Private Insurance* (Oct. 25, 2022), https://oversightdemocrats.house.gov/sites/democrats.oversight.house.gov/files/2022-10-25.COR%20PBM-Insurer%20Report.pdf.

[61] 45 C.F.R. § 156.122(a)(1).

[62] The six categories are anticonvulsants, antidepressants, antineoplastic, antipsychotics, antiretrovirals, and immunosuppressants. *See* 42 U.S.C. § 1395w-104(b)(3)(G)(iv).

We also support requiring state Exchanges and SBE-FPs to review plan networks before they certify them, rather than simply accepting the issuer's attestation that it meets network adequacy standards. Further, we support the requirement that state Exchanges and SBE-FPs collect data from issuers about whether providers in their network offer telehealth services, and we appreciate the clarification that this information-gathering does not suggest that telehealth services are a substitute for in-person services for the purpose of assessing network adequacy.

We urge the Department to take additional steps to expand network adequacy standards for all Exchanges. Standards that only measure the types and locations of providers are not sufficient to ensure that enrollees in fact have access to care. For example, some networks may have a sufficient number of nearby providers but few who are actually accepting new patients. Some networks may be full of providers who have prohibitively long wait times for appointments, or who only see patients during limited hours of the day. Some have an insufficient number of providers who have the cultural competency training to work with particular underserved populations, the linguistic competency to treat people whose primary language is not English, or infrastructure that is accessible for people across a range of disabilities. Additionally, providers in a network might not provide all covered services within their scope of practice: For example, if a QHP contracts with a geographically sufficient number of OB-GYNs but none of them provide family planning services, enrollees will not have meaningful access to those services. Similarly, many providers do not offer gender-affirming care even when it is within their scope of practice, meaning that time and distance standards alone may not measure enrollees' actual access to these services. This problem may be particularly exacerbated in states that provide extensive refusal rights for providers to deny care based on personal beliefs.

Accordingly, the Department should establish a wider range of network adequacy standards across federal and state Exchanges, including standards regarding:

- wait times across all specialties and provider types;
- the number of providers with extended hours of operation;
- the scope of perinatal providers, particularly the inclusion of midwives and doulas rather than only OB-GYNs;
- the number of providers with cultural competency certification in working with a range of underserved populations;
- the number of in-network providers with proficiency in the most frequently spoken languages in the state or county; and
- the number of providers that comply with the Medical Diagnostic Equipment Accessibility standards.

V. Conclusion

We appreciate the opportunity to comment on this proposed rule. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further information, please contact Ma'ayan Anafi, Senior Counsel for Health Equity and Justice at the National Women's Law Center, at manafi@nwlc.org.