**SPAN Parent Advocacy Network & Family Voices-NJ comments on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025**

January 4, 2024

Thank you for the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2025. The SPAN Parent Advocacy Network (SPAN) is NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and RSA Transition Parent Information and Training Center. We are the NJ State Affiliate Organization (SAO) of Family Voices, the NJ State Organization of the Federation of Families for Children's Mental Health, and the NJ affiliate of Parent-to-Parent USA. We also house a Military Family 360 Support program. Our comments today are based on our 35 years of work supporting diverse families in advocacy on behalf of their children as well as in systems improvement activities across healthcare.

I. Executive Summary

We understand that the proposed changes relate to new ACA provisions and a change to Medicaid financial eligibility.

II. Background

We appreciated the background information including the legislative overview, stabilizing premiums, finalizing Exchange standards, EHBs (essential health benefits), waivers, CO-Ops (Consumer Operated and Oriented Plans), BHP (Basic Health Program), and Medicaid income disregards. Our comments appear under each section below.

B. Summary of Major Provisions
1. 31 CFR Part 33 and 45 CFR Part 155

We **support** the proposal for state public hearings to also be available in a virtual or hybrid formats, equal to an in-person meeting.

2. 42 CFR Part 435

Currently, States must apply income disregards to all individuals within each Medicaid eligibility group.

35 Halsey St.
Newark, NJ 07102
973-642-8100
www.spanadvocacy.org

The proposal will allow flexibility to "to target disregards at discrete members of individuals within an eligibility group" but we are **concerned** with possible unintended consequences for vulnerable populations.

3. 42 CFR Part 600

We **support** adding "an option to the effective date of coverage rules that would allow States to start coverage on the first day of the month…"

4. 45 CFR Part 153

We acknowledge the proposal to "recalibrate the 2025 benefit year HHS risk adjustment models using the 2019, 2020, and 2021 benefit year enrollee-level EDGE data". However, we would suggest minimizing the impact of 2020 data due to the pandemic.

5. 45 CFR Part 155

We **support** that new state Exchanges must first operate a state Exchange based on the federal platform for at least one plan year. We also **agree** with the proposal for a state application to submit a blueprint and "supplemental documentation to HHS detailing the State's implementation of its State Exchange functionality". This would include prohibition on discrimination, cost sharing, annual/lifetime limits, and other consumer protections such as live representatives at call centers. We **support** a "centralized eligibility and enrollment platform" as well as a "single, streamlined application". We understand that the "State's EHB benchmark plan would not be considered in addition to EHB" as duplicative. We **support** maintaining records "of all effectuated enrollments in QHPs [qualified health plans]".

We also **agree** that the "HHS reconsideration entity is the CMS Administrator…agents, brokers, and web-brokers utilizing the FFEs and SBE–FPs can submit a request to the CMS Administrator". We **support** applying standards "to web-brokers and Direct Enrollment (DE) entities…HealthCare.gov changes…Exchange websites within a notice period set by HHS".

We **support** the proposal that Exchanges are "required to send notices to tax filers for the first year in which they have been determined to have failed to reconcile APTC [advanced premium tax credit] as an initial warning".

We also **agree** to self-attestation of incarceration status without further verification.

We understand that the Federal Data Services Hub will "access and use the income data provided by the Verify Current Income (VCI) Hub". This will verify "a tax household's annual income attestation for Exchange QHP eligibility and the Medicaid".

We **agree** with periodic "checks for deceased enrollees twice yearly".

We also **support** the proposal to "re-enroll individuals who are enrolled in catastrophic coverage".

We understand that there will be flexibility for issuers "experiencing billing or enrollment problems due to high volume or technical errors is not limited to extensions of the binder payment" as more time for the initial payment will also benefit consumers.

We **support** that "State Exchanges must 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" to allow enough lead time for enrollment. We also **support** the proposal that "coverage that is effective on the first day of the month following plan selection". We understand that the parameters will be revised "around the availability of a special enrollment period for APTC-eligible".

We acknowledge the proposal to "retroactively terminate… when the enrollee enrolls in Medicare" but are **concerned** that this may cause billing issues for consumers due to coordination of benefits, particularly retroactively when claims have been paid.

We **strongly support** "quantitative time and distance network adequacy".

6. 45 CFR part 156

We understand the proposal for "user fee rates… for all issuers participating on the Exchanges". We **agree** with consolidating "the options for States to change EHB-benchmark…benefits that is equal to the scope of benefits of a typical employer plan in the State…[and] submit a formulary drug list as part of their application".

We **agree** with the proposal "to remove the regulatory prohibition at § 156.115(d) on issuers from including routine non-pediatric dental services as an EHB, which would provide States the option to add routine" care.

We acknowledge that there are minor updates to metal levels of plans.

We **disagree** with the proposal to "offer non standardized plan options in excess of the limit of two per product network type, metal level, inclusion of dental and vision benefit coverage" as we have found that nonstandard plans are often substandard for consumers.

We acknowledge the "conforming amendments to the payment and collections…and that administrative fees for utilizing the No Surprises Act Federal independent dispute resolution (IDR)".

III. Provisions of the Proposed Regulations

A. 31 CFR Part 33 and 45 CFR Part 155—Section 1332 Waivers
1. Background
2. Proposed Amendments to Normal Public Notice Requirements (31 CFR 33.112, 31 CFR 33.120, 45 CFR 155.1312, and 45 CFR 155.1320)

Although we **strongly disagree** that "States may submit a request to the Departments to modify, in part, the State public notice requirements", we do **support** the option to "host public hearings and post-award forums virtually, and that they would like to continue doing so to facilitate attendance".

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.

1. Increase State Flexibility in the Use of Income and Resource Disregards for Non-MAGI Populations (42 CFR 435.601)

We acknowledge the proposal to "provide States with greater flexibility to adopt income and/or resource disregard…[for] modified adjusted gross income ('MAGI-based methodologies')".

We are **concerned** with the proposal of an "optional eligibility category at section 1902(a) (10) (A)(ii)(V) of the Act and a population in section 1905(a) of the Act (for example, individuals 65 years old or older) forms a singular eligibility group" as this often results in inequities even if "a State's use of a less restrictive methodology for an eligibility group would never alter the amount, duration, and scope of medical assistance available within the group".

We are **concerned** "nothing in section 1902(a) (17) of the Act should be construed as prohibiting a State from adopting income or resource disregards under section 1902(r)(2) of the Act exclusively for people who need home and community-based services (HCBS)" as this is a vulnerable population.

As stated above, we **disagree** with the proposal to "eliminate paragraph (d)(4) from 42 CFR 435.601, which would allow States to target income and/or resource disregards at discrete subpopulations in the same eligibility group". We disagree that this will "increase State flexibility and provide States more options to extend eligibility to specific populations" but rather perpetuate inequities.

2. Changes to the Basic Health Program Regulations (42 CFR 600.320)

As stated above we do **agree** with the proposal "to revise § 600.320(c) to add a third option at paragraph (c)(iii) that would allow a State operating a BHP to follow an effective date of eligibility for all enrollees on the first day of the month following the month in which BHP eligibility is determined".

C. 45 CFR Part 153—Standards Related to Reinsurance, Risk Corridors, and HHS Risk Adjustment
1. Sequestration

We acknowledge that this is "sequestered at a rate of 5.7 percent".

2. HHS Risk Adjustment (§ 153.320)

We understand that this will "predict average group costs to account for risk across plans".

a. Data for HHS Risk Adjustment Model Recalibration for the 2025 Benefit Year

As stated above, we acknowledge the proposal to "recalibrate the 2025 benefit year HHS risk adjustment… 2019, 2020, and 2021 enrollee-level EDGE data" but minimizing the impact of 2020 data due to COVID.

b. Pricing Adjustment for the Hepatitis C Drugs

We acknowledge the proposal to "continue applying a market pricing adjustment to the plan liability associated with Hepatitis C drugs".

c. Proposed List of Factors to Be Employed in the HHS Risk Adjustment Models (§ 153.320)

We appreciated the data in Tables 1 through 6.

d. Cost-Sharing Reduction Adjustments

We acknowledge the proposal to "recalibrate the CSR adjustment factors for AI/AN zero cost sharing and limited cost sharing CSR plan variant enrollees for the 2025 benefit year and retain these".

e. Model Performance Statistics

We acknowledge the proposal to "examine each model's R-squared statistic and predictive ratios (PRs)".

3. Overview of the HHS Risk Adjustment Methodology (§ 153.320)

We understand that this proposal will "continue to use the State payment transfer formula finalized in the 2021 Payment Notice for the 2022 benefit year and beyond" and that there are no changes to the formula.

4. HHS Risk Adjustment User Fee for the 2025 Benefit Year (§ 153.610(f))

We acknowledge that there is a "HHS risk adjustment user fee for the 2025 benefit year of $0.20 PMPM".

5. Audits and Compliance Reviews of Risk Adjustment Covered Plans (§ 153.620(c))

We **support** the amendment regarding "any corrective action plans when required by HHS if a high cost risk pool audit results in the inclusion of a finding or certain observations". This is particularly true "when there is evidence of non-compliance with applicable Federal requirements if required by HHS to improve program and data integrity for accurate data submissions to issuer EDGE servers".

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

1. Approval of a State Exchange (§ 155.105)

As stated previously, we **strongly support** the proposal for state Exchanges to "first operate a State-based Exchange using the Federal platform (SBE–FP), meeting all requirements under § 155.200(f), for at least one plan year".

2. Election to Operate an Exchange After 2014 (§ 155.106)

Again as stated above we **agree** with the requirement "that the State provide supporting documentation demonstrating progress toward meeting State Exchange Blueprint requirements, or documentation that details a State's plans for how it intends to implement and meet the Exchange functional requirements as laid out in the State Exchange Blueprint". In addition, we **strongly support** that when a state submits a blueprint application that "the State must provide the public with notice and a copy of its State Exchange Blueprint application".

3. Additional Required Benefits (§ 155.170)

As stated above, we **agree** that the "EHB-benchmark plan would not be considered in addition to EHB and thus would not be subject to defrayal" as it is duplicative. We also **agree** with the addition that "a 'covered benefit in the State's EHB-benchmark plan' is considered an EHB".

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

We **strongly support** "minimum standards for Exchange call center operations". We understand that the following requirements include "live call center … [that is] able to assist with QHP application". It is reassuring that currently "all State Exchange call centers already meet minimum".

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

As stated above, we **agree** with a "platform on the Exchange's website single, streamlined application for enrollment in a QHP and insurance affordability programs by consumers [and that the] Exchange… is the entity responsible for making all determinations". We previously **supported** the provision to "maintain records of all effectuated enrollments in QHPs, including changes in effectuated QHP Enrollments". Again, we **agree** that the Exchange is the "sole entity responsible for conducting eligibility determinations" despite the use of web-brokers. In addition, we **agree** that the Exchange is responsible for "the websites and eligibility platforms provided by non-Exchange entities may not include…Medicaid and CHIP…[to] address these Gaps".

6. Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220(h))

As stated above we **agree** with the proposal to change "'the HHS reconsideration entity' and replacing them with 'the CMS Administrator' and by specifying that, instead of the HHS reconsideration entity, the CMS Administrator" will be used if terminated for cause and "reconsideration would be made to the CMS Administrator".

7. 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 **agree** with minimum "HHS standards governing web-broker non-Exchange website display of standardized QHP comparative information, disclaimer language, information on eligibility for APTC/CSR" for consistency.

8. Establishing Requirements for DE Entities Mandating HealthCare.gov Changes Be Reflected on DE Entity Non-Exchange Websites Within a Notice Period Set by HHS (§ 155.221(b))

We **agree** that this must include "changes that enhance the consumer experience, simplify the plan selection process, and increase consumer understanding of plan benefits, cost sharing responsibilities, and eligibility for financial assistance" and also **agree** with codifying the "existing practice of communicating important changes to the *HealthCare.gov* display to EDE entities to ensure their EDE websites conform".

9. Adding and Amending Language to Ensure DE Entities Operating in State Exchanges Meet Certain Standards Applicable in the FFEs and SBE–FPs (§ 155.221)

We **agree** with extending "certain existing HHS standards to DE [direct enrollment] entities operating in State Exchanges to permit DE entities to assist their consumers and applicants with direct enrollment in QHPs and applying for APTC/CSRs in a manner that constitutes enrollment through an Exchange".

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

Again we **support** the proposal "to send notices to tax filers for the first year in which they failed to reconcile APTC".

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

Here again we **agreed** with the applicant's attestation of incarceration.

12. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

As stated previously, we understand that this proposal will "access and use the income data provided by the optional Verify Current Income (VCI) Hub service as a State Exchange or a State Medicaid and CHIP agency function".

13. Eligibility Redetermination During a Benefit Year (§ 155.330(d))

Again we **agree** with the proposal to "conduct periodic checks for deceased enrollees twice yearly and subsequently end deceased enrollees' QHP coverage beginning with the 2025 calendar year".

14. Incorporation of Catastrophic Coverage into the Auto Re-Enrollment Hierarchy (§ 155.335(j))

We understand that "catastrophic coverage as defined in section 1302(e) of the ACA into a new QHP for the coming plan year" and **agree** with the proposal for reenrollment as stated above.

15. Premium Payment Deadline Extensions (§ 155.400(e)(2))

Here again we **agreed** to "codify that the flexibility for issuers experiencing billing or enrollment problems due to high volume or technical errors, or issuers directed to do so by applicable State or Federal authorities, is not limited to extensions of the binder payment".

16. Initial and Annual Open Enrollment Periods (§ 155.410)

We **support** revising "parameters around the adoption of an alternative open enrollment" which would begin "on November 1 of the calendar year preceding the benefit year and ends no earlier than January 15" as stated above.

17. Special Enrollment Periods
a. Effective Dates of Coverage (§ 155.420(b))

We **agree** that for "ease of consumer experience and to prevent coverage gaps" for consumers to receive coverage beginning the first day of the month after the consumer selects a QHP", as stated previously.

b. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Household Income at or Below 150 Percent of the Federal Poverty Level

We acknowledge the technical change from "'no greater than' to 'at or below' for improved readability and understanding".

18. Termination of Exchange Enrollment or Coverage (§ 155.430)

As stated above, we have **concerns** regarding coordination of benefits when retroactively terminating "enrollment in a QHP through the Exchange when the enrollee enrolls in Medicare Parts A or B retroactively".

19. Establishment of Exchange Network Adequacy Standards (§ 155.1050)

We stated previously we **strongly support** a "quantitative time and distance QHP network adequacy standards".

a. Federal Network Adequacy Policy Under the Affordable Care Act
b. Network Adequacy Standards and Reviews Across Exchanges

We **agree** with network adequacy standards and understand that "uniform network adequacy standard does not exist for States served by State Exchanges".

c. Proposals Related to State Exchange and SBE–FP Network Adequacy Standards and Reviews

Here again, we **support** the use of "quantitative time and distance" standards for network adequacy and plan compliance.

i. Quantitative Network Adequacy Time and Distance Standards

We **agree** that these network adequacy standards must be "at least as stringent as the FFEs' time and distance standards".

ii. Quantitative Network Adequacy Reviews

We **strongly support** the proposal to "conduct quantitative network adequacy reviews prior to QHP certification". This should include up-to-date directories of providers accepting new patients and participating plans.

iii. Quantitative Network Adequacy Review Justification Process

We **strongly disagree** with the proposal if issuers are "unable to meet the specified standards to participate in a justification process" as this will result in lack of consumer access to care.

iv. Exception Process for State Exchanges and SBE–FPs

Here again, we **disagree** with "granting exceptions to the requirements that State Exchanges and SBE–FPs are required to establish and impose network adequacy time and distance standards for QHPs".

d. Proposal Related to QHP Reporting on Telehealth Services

We **strongly agree** with the proposal to include "whether network providers offer telehealth services".

f. Additional Network Adequacy Standards [sic]

We understand that this proposal does not address "appointment or wait time standards" which is **concerning** as certain pediatric specialists have wait lists of 6-9 months.

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

1. FFE and SBE–FP User Fee Rates for the 2025 Benefit Year (§ 156.50)

a. FFE User Fee Rates for the 2025 Benefit Year

We acknowledge that this proposal is based "on estimated costs".

b. SBE–FP User Fee Rates for the 2025 Benefit Year

We acknowledge that the user fee is proposed at "1.8 percent".

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

We understand that for EHB-benchmark plans, the proposal is to "revise the scope of benefit requirement" and this would include the requirement to "submit a formulary drug list".

a. Consolidating the State EHB Benchmark Plan Options

We acknowledge that a "State may change its EHB-benchmark plan by selecting a set of benefits that would become the State's EHB-benchmark plan".

b. Scope of Benefit Requirements

We **strongly agree** that benefits must be "equal to the scope of benefits of a typical employer plan in the State".

c. Drug Formularies

We understand that plans must "submit a formulary drug list as part of their documentation provided to change EHB-benchmark plans only if the State is seeking to change its prescription drug EHB".

3. Provision of EHB (§ 156.115)

As stated above we **agree** with the proposal to remove the "prohibition on non-pediatric dental services".

4. Prescription Drug Benefits (§ 156.122)

We **agree** with codifying the "EHB policy related to prescription drugs in excess of the benchmark".

a. Classifying the Prescription Drug EHB

We understand this proposal examines "risks and benefits… replacing the reference to the USP MMG with a reference to the USP DC… [as a] means of classifying the drugs require to be covered".

b. Coverage of Prescription Drugs as EHB

We **agree** that "prescription drugs in excess of those covered by a State's EHB benchmark plan are considered EHB".

c. Pharmacy and Therapeutics Committee Standards

We **strongly agree** that the P&T committee must include a consumer representative as a stakeholder.

5. Publication of the 2025 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130)

We understand it is proposed to "publish the premium adjustment percentage the required contribution percentage, and maximum annual limitations on cost sharing and reduced maximum annual limitation on cost sharing" as a consumer protection.

6. Standardized Plan Options (§ 156.201)

As stated above we acknowledge the minor updates of "AVs within the permissible de minimis range for each metal level".

7. Non-Standardized Plan Option Limits (§ 156.202)

As stated above, we **strongly disagree** with the proposal to "allow issuers to offer additional non-standardized plan options (in excess of the limit of two) per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area for PY 2025 and subsequent plan years, if issuers demonstrate that these additional nonstandardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions" as these plans will not benefit consumers, particularly those with chronic conditions.

8. CO–OP Loan Terms (§ 156.520)

We acknowledge the proposal for CO-Ops to "voluntarily terminate their loan agreement with CMS, and thereby cease to constitute a qualified non-profit health insurance issuer (QNHII)" but caution this must be done with advance notice to consumers.

9. Conforming Amendment to Netting Regulation to Include Federal IDR Administrative Fees (§ 156.1215

We acknowledge the use of administrative "fees for utilizing the No Surprises Act Federal IDR process for health insurance issuers that participate in financial programs under the Patient Protection and Affordable Care Act".

We have no further comments after this section

Thank you again for the opportunity to provide input on the proposed payment parameters.

Sincerely,

Carolyn Hayer
Executive Co-Director, SPAN
35 Halsey St., 4th Fl.
Newark, NJ 07102
chayer@spanadvocacy.org
spanadvocacy.org

Lauren Agoratus, M.A.-parent
NJ Coordinator- Family Voices @ SPAN
35 Halsey St., 4th Fl.
Newark, NJ 07102
familyvoices@spanadvocacy.org
spanadvocacy.org

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***To empower families and inform and involve professionals and other individuals interested in the healthy development and education of children, to enable all children to become fully participating and contributing members of our communities and society.***