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January 27, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244–1850

**Re: CMS–9911–P - Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023**

Dear Administrator Brooks-LaSure:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule referenced above.

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

AKF appreciates that CMS is proposing several changes in this rule that aim to improve shopping for affordable health care coverage, strengthen access to care, and advance health equity for consumers purchasing Marketplace coverage. Our comments on specific CMS proposals are below.

**Nondiscrimination Policy for Health Plan Designs**

AKF appreciates CMS' proposal to refine and clarify the essential health benefit (EHB) rules prohibiting discriminatory benefit designs, particularly as it pertains to benefit limitations and plan coverage requirements. Specifically, CMS proposes "that a nondiscriminatory benefit design that provides EHB is one that is clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current and relevant peer-reviewed medical

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journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources."

We support this proposal and agree that benefit designs need to be based on relevant clinical evidence to ensure they are not discriminatory. As CMS moves forward with this proposal, we urge the agency to be mindful of bias based on race, ethnicity, or disability that exists in the medical research field and that can still find its way in reputable sources. We urge CMS to ensure the clinical evidence that may be used to justify a benefit design is not biased or discriminatory in nature. We also recommend that CMS consider implementing a process in which consumers can report on their experience with a plan benefit design that may be discriminatory.

**Nondiscrimination Based on Sexual Orientation and Gender Identity**

AKF strongly supports CMS' proposal to reinstate protections that would explicitly prohibit marketplaces, issuers, agents, and brokers from discriminating against consumers based on sexual orientation and/or gender identity. An essential component of advancing health equity is to ensure no one is discriminated against because of who they are when trying to access coverage and care. We applaud CMS for its proposal to restore the nondiscrimination protections for the LGBTQI+ community that were removed in the 2020 rule.

**User Fee Rates for the 2023 Benefit Year**

CMS proposes Qualified Health Plan (QHP) issuer user fee rates for the 2023 plan year of 2.75% of total monthly premiums for the federally-facilitated exchanges (FFEs) and 2.25% for state-based exchanges on the federal platform (SBE-FP). These rates are the same as the revised 2022 rates that CMS finalized in last year's Improving Health Insurance Markets for 2022 rule, which partially reversed the initial 2022 user fee rates that were lower. We appreciate CMS' commitment to ensuring the issuer user fee is adequate to sustain essential exchange-related activities, such as consumer information and outreach programs, and we appreciate CMS' proposal to at least maintain the 2022 levels. However, we recommend that CMS consider further investment in essential exchange functions and suggest user fee levels be set at the higher levels that were implemented before 2022.

**Essential Health Benefits: Cross-Category Substitution**

AKF supports CMS' proposal to prohibit benefit substitution between EHB categories, which was previously permitted under a revision to EHB benchmark rules in the 2019 Payment Notice. AKF opposed that decision and expressed our concern that permitting issuers to substitute services between EHB categories could lead to inadequate coverage of critical services for chronic conditions. People with costly chronic diseases, such as kidney disease, could see cuts or substitutions in their benefit coverage that could limit or exclude services that are vital to their care. As CMS notes in this proposed rule, no state has notified CMS that it was allowing this additional flexibility for issuers or has even approached the agency to discuss the merits of doing so. We are pleased to see and agree with CMS' view that the 2019 policy "may only create potential harm for consumers with chronic

conditions and disabilities," and that "whatever theoretical flexibility this policy could have afforded to states, such untapped flexibility is not justified given the potential negative effects on consumers."

**Standardized Plan Options**

AKF supports CMS' proposals with regards to standardized plan options on FFEs and SBE-FPs. Specifically, we support CMS' proposals to require insurers to offer a standardized plan at every product network type, metal level, and throughout every service area that they offer non-standardized options. We support CMS' proposal to differentially display standardized options on HealthCare.gov, to make it easier for consumers to identify them. We strongly support CMS' proposal to include copays instead coinsurance in standardized plans for several categories, including primary care, urgent care, specialist visits, mental health/substance use disorder outpatient care, and all drug tiers. AKF also supports the proposal to exclude from the deductible services for primary care, urgent care, specialist visits, mental health/substance use disorder outpatient care and for some drugs.

AKF agrees with CMS' view that requiring standardized plan options will improve affordability by providing greater access to pre-deductible coverage and requiring copays instead of coinsurance for certain services and for all drug tiers. People with chronic conditions such as kidney disease, who often also have other comorbidities, have greater health needs, and may need access to high-cost drugs. Using copays instead of coinsurance for certain provider visits and for all drug tiers in standardized plans will provide improved cost predictability for consumers when choosing a plan. We also agree that standardized plans will improve and simplify the plan shopping experience by making it easier to draw meaningful comparisons between plans. Because kidney disease disproportionately affects communities of color and other underserved populations, standardized plan options could help address health disparities by providing another way to lower cost barriers for needed services and treatments for kidney disease and other comorbidities.

We recommend that CMS strengthen its standardized plan proposals by expanding the use of copays for additional categories, including emergency room visits, inpatient hospital services, imaging, and labs. These are services that people with chronic conditions are likely to use. We also recommend that CMS lower the copay and deductible amounts in the standardized plan options, as they are still quite high for many consumers. For example, the deductible for the bronze standardized option is $9,100, an amount that would dissuade many low-income people who might choose the plan because of premium cost from seeking needed medical services subject to the deductible.

**Network Adequacy**

AKF shares CMS' view that "strong network adequacy standards are necessary to achieve greater equity in health care and enhance consumer access to quality, affordable care through the marketplaces." This is especially true for people living with kidney disease seeking a plan that has an adequate network of providers that can help them effectively manage their chronic condition and other comorbidities they may have. Therefore, we strongly support CMS' proposal to evaluate the adequacy of provider networks in the FFEs during the annual plan certification process.

Specifically, we support the proposal to evaluate marketplace plan networks using the quantitative time and distance standards and appointment wait time standards. Using a robust set of quantitative standards will provide needed clarity for insurers and consumers and allow for a more uniform application of federal network adequacy standards in the FFEs.

We support the proposal that plans that use tiered networks would be evaluated for network adequacy based on their lowest cost-sharing tier. This will ensure that network adequacy is also taking into account affordability, and that access to only the costliest providers with the highest out-of-pocket costs for consumers is not used to meet network adequacy standards.

We support CMS' clarification that telehealth services may not be counted in place of in-person service access for network adequacy purposes in 2023. While telehealth can be a useful supplement to accessing care, its clinical appropriateness is very much dependent on the individual and their circumstances. Patients, in consultation with their provider, should decide on whether telehealth is appropriate for them. We appreciate that CMS' clarification ensures telehealth is not used as a substitute for in-person care as it relates to network adequacy.

AKF also wants to voice our support for CMS' proposal to strengthen essential community provider (ECP) standards, by requiring insurers in 2023 to include at least 35 percent of available ECPs (an increase from the current 20 percent), and to require ECPs to be on the lowest cost-sharing tier to count towards the ECP requirement for plans that used tiered networks. ECPs provide essential care to underserved communities, and as CMS notes, 80 percent of issuers on FFEs had at least 35 percent of ECPs in their network for plan year 2021 and therefore would already meet this standard.

To further strengthen CMS' network adequacy standards proposal, we recommend adding a quantitative standard that ensures a network includes a sufficient number of providers that are accepting new patients throughout the year. We also recommend CMS evaluate networks for how well they provide access to culturally and linguistically appropriate care. The evaluation would ensure providers can meet the language needs for consumers with limited English proficiency and provide culturally appropriate care that is attuned to the diverse background of a community, including populations that have been traditionally underserved.

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

Sincerely,

LaVarne A. Burton
President and CEO