

January 8, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted via Regulations.gov

Re: CMS-2023-0191, RIN 0938-AV22 - Patient Protection and Affordable Care Act, Notice of Benefit and Payment Parameters for 2025

Dear Administrator Brooks-LaSure:

Families USA is a leading national, non-partisan voice for health care consumers dedicated to the achievement of high-quality, affordable health care and improved health for all. We write to comment on the proposed notice of benefit and payment parameters for 2025. Families USA appreciates CMS's work to improve health insurance marketplace standards. Over 16 million people depend on state and federal marketplaces for their health coverage.¹ The benefit and payment parameter rule is critical for consumers, as it ensures the availability of quality coverage and helps prospective enrollees receive accurate and necessary information about available plans, including information that enables them to compare covered benefits, cost sharing, provider networks, and quality ratings. As noted below, the rule also contains many important standards for health insurance plans offered on the marketplace to offer standardized benefits, for marketplaces themselves to establish reasonable enrollment periods, and for the agents, brokers, direct enrollment entities and assisters that help marketplace enrollees to provide correct and unbiased information that guides their marketplace plan selections. Consumers depend on these standards so that their insurance covers what they need and is there when they need it. With that perspective, our comments focus on the following areas:

- Requirements for state-based marketplaces (SBMs), including those operating on the federal platform, (§155.205) to provide consumer assistance and streamlined eligibility determinations.
- Standards for web brokers and direct enrollment entities (§155.220 and §155.221).
- Network adequacy standards (§155.1050 and §156.230).
- Essential health benefits (§156.115).

Following our comments focused on those sections, we also briefly highlight our support for many other sections in the proposed rule.

Consumer assistance tools and programs of an exchange (§155.205)

Families USA supports the addition of call center standards, including access to a live call center representative during published operating hours, and the requirement for exchanges to operate a centralized eligibility and enrollment platform on the exchange's website. Live call center support has been shown to be particularly important for people with limited health insurance literacy, computer literacy, or internet access.² As noted in the preamble, live assistance also helps consumers troubleshoot

application issues in real time. A centralized eligibility platform allows consumers to submit a single application for enrollment in a qualified health plan (QHP) and in insurance affordability programs, appropriately ensuring that government entities and their contractors make eligibility decisions, that all applicants have access to the same information, and that they receive information about their appeal rights.

Families USA urges the administration to also provide and require readily accessible web information about assisters, and accurate information about Medicaid pathways, in states that are using the federal platform and transitioning to a state exchange. As drafted, the proposed amendments require centralized eligibility and enrollment functions, but do not yet require sufficiently prominent information for consumers in a state-based exchange using the federal platform (SBE-FP). More information about assisters and about Medicaid eligibility pathways should be available on the enrollment platform itself or through direct links from the federal platform to appropriate pages of the state platform. For example, currently, Georgia is using the federal platform while transitioning to a state-based exchange, but consumers are still in need of additional improvements to the federal website in order to make informed enrollment decisions. On the healthcare.gov “[find assistance](#)” page,³ users are directed to choose between “find an assister or agent/broker” and “get contacted by an agent or broker.” However, if one clicks on “find an assister or agent/broker” and then enters a Georgia zip code, the [next screen](#) currently lists *only* agents and brokers and makes no mention of assisters. A second click on the word “assisters” brings the user to [a page](#) that prominently says “showing 0 assisters near [Atlanta, GA],” and in another place says “Georgia certifies its own Assistors - [Visit your state's website to find assistance near you.](#)” It is easy to overlook the language directing users to click through to the state website. In fact, navigators often inform us that people miss this information and find only agents and brokers rather than assisters.⁴ Accordingly, in SBE-FP states, when users click on the word “assisters” on the “[results page](#)” it should send users directly to the state’s website to find assisters. The search for local assisters is much simpler in federal exchange states in which the federal government performs all marketplace functions, and in most state-based exchanges. **Though 155.205(b)(3) already requires exchange websites to include information about navigators, CMS should make key improvements to require that this information is readily accessible in SBE-FP states: Within one click, consumers searching for local help should be able to find certified navigators and assisters as distinct from agents and brokers.**

In addition, enrollees need information about Medicaid eligibility pathways to be more readily accessible, particularly when it comes to Medicaid waiver programs. For example, in Georgia, the single application for advance premium tax credits and Medicaid does not screen for eligibility in Pathways to Coverage, a Georgia Medicaid waiver program.⁵ We urge the administration to work with Georgia to correct this problem and prevent it from occurring in other states. **Rules and operational procedures should assure prospective enrollees of complete and accurate information about all marketplace and Medicaid eligibility pathways, including those provided under waiver. In state exchanges using the federal platform, CMS should ensure that operationally, links and insurance affordability application forms direct consumers to all available Medicaid options.**

Standards for web brokers and direct enrollment entities (§155.220 and §155.221)

In the proposed rule, HHS would require that state-based marketplaces (SBMs) operate centralized eligibility and enrollment platforms on their websites (or, in the case of SBMs using the Federal platform, on the Federal website). The proposal codifies the existing requirement that the Marketplace is the

entity responsible for making all eligibility determinations, regardless of whether the individual files an application through the Exchange’s website or through a different website, such as a web broker or direct enrollment entity. HHS also proposes that existing standards for web broker displays of plan information and standards of conduct (originally only applicable to federally-run Marketplaces) apply across all Marketplaces, whether state or federally-run and that direct enrollment entities be required to display Marketplace and non-Marketplace plans on separate pages on their websites and to limit advertising for non-Marketplace plans during open enrollment periods for the Marketplace. As explained below, Families USA supports these changes and has observed the need for improved standards through our own research. We advocate further requirements concerning the display of information.

Families USA supports these new, more stringent standards governing the behavior of web brokers and direct enrollment entities. CMS notes that there has been increased interest among SBMs in using web brokers to facilitate enrollment and though no SBM currently operates a direct enrollment program, there has been increased interest in this pathway among states, including Georgia. These new safeguards would reduce confusion among consumers using web brokers or the direct enrollment process to enroll in Marketplace plans⁶, rather than the Marketplace website and would clarify that the Marketplace, and not individual plans, is responsible for making all eligibility determinations.

In previous comments to the Center for Consumer Information and Insurance Oversight (CCIIO), Families USA described our findings from an exploration of enhanced direct enrollment websites in September 2020⁷: some provided incomplete information about special enrollment opportunities during the pandemic; some asked for irrelevant personal information, such as weight; and some did not screen for all categories of Medicaid. Standards for direct enrollment entities should address these problems in state-run exchanges as well as in the federally facilitated exchange.

Web brokers are not required to display all available plans in the marketplace, and instead often preferentially display the plans that pay them the highest commissions. This incomplete information about plan choices can confuse consumers.⁸ CMS proposes that web brokers include language on their websites explaining that they are not the federal or state exchange and explaining that prospective enrollees can get information about all available QHPs through the applicable federal or state exchange website. We support the required display of such disclaimers. They will help consumers who want information about other options to find it. **However, we recommend that CMS ensure that disclaimers are thoroughly consumer-tested for readability. CMS should also conduct consumer testing to determine whether such explanations are sufficiently prominent on websites so as not to be overlooked. Further, CMS should prohibit screening tools on the front pages of web broker sites from asking for irrelevant information – in particular, they should not collect information about health conditions, which cannot legally be taken into account in the sale of qualified health plans.**

For example, current disclaimer language on broker websites is similar to the following. (Much of this disclaimer language is provided by HHS):

“Attention: This website is operated by Ideal Concepts, Inc., parent company of InsureMe, Inc., and is not the Health Insurance Marketplace® website. In offering this website, Ideal Concepts is required to comply with all applicable Federal law, including the standards established under 45 CFR §§155.220(c) and (d) and standards established under 45 CFR §155.260 to protect the privacy and security of personally identifiable information. This website may not support enrollment in all Qualified Health Plans (QHPs) being offered in your state through the Health Insurance Marketplace® website. For enrollment

support in all available QHP options in your state, go to the Health Insurance Marketplace® website at HealthCare.gov.”⁹

Consumers will not know what the cited standards do. At a minimum, the regulatory citations should link to more information about those standards.

Further, to get a quote from this particular vendor, one must enter their health conditions, height and weight, all of which are irrelevant to marketplace coverage, yet this entity is listed as a certified enrollment partner on <https://www.healthcare.gov/direct-enrollment/>¹⁰.

Network adequacy standards (§155.1050 and §156.230)

We support the proposed changes in §155.1050 and §156.230, and also recommend that CMS require the following:

- a) Make appointment wait time standards as stringent as those of the federal exchange. Federal marketplace plans by rule (§156.230) must adhere to appointment wait time standards that are further defined in annual guidance. These will help to ensure that an adequate number of providers are available to provide timely access to care, and should be applied as minimum standards in all states.**
- b) Make adherence in state-based exchanges, as well in the federal exchange, at a minimum to the standards set forth in §156.230 (b) through (e) which ensure accurate provider directories, notification of provider terminations, and limit cost-sharing for out-of-network ancillary service providers.**

The proposed rule would require health plans in state exchanges, including those operating on the federal platform, to adhere to quantitative time and distance standards that are at least as stringent as the federal exchange’s network adequacy standards. (These standards speak to the amount of time it takes to travel to a network provider’s office and how far away the offices are in miles in rural, urban, and suburban regions.) If issuers could not meet such standards, they would need to justify any variations. State exchanges would be required to conduct network adequacy reviews of qualified health plans prior to certification. Families USA supports these changes as they would help to ensure that providers will actually be accessible to plan enrollees and incentivize plans to adequately serve various localities. Several states do not yet have network adequacy laws and regulations that are as strong as the federal requirements, and enrollees in those states may therefore have to travel long distances to a provider that will accept their insurance.¹¹ Moreover, lengthy legislative and regulatory processes and staff shortages can delay states from promptly improving their standards.¹²

However, the proposed rule stops short of requiring health plans in state exchanges to adhere to current requirements for plans on federal exchanges. All of these standards should be the minimum standard for state-based exchanges, as described below.

Wait time standards

With respect to wait time standards, consumers should have the right to timely medical appointments wherever they live. If timely appointments are not available in a health shortage area, plans should be required to document which specific services are affected and their efforts to make alternative arrangements for enrollees. The 2025 draft letter to issuers in federally-facilitated exchanges requires

QHPs to ensure that enrollees are able to schedule an appointment within set numbers of business days (e.g. 10 business days for behavioral health, 15 business days for routine primary care, and 30 business days for non-urgent specialty care) at least 90 percent of the time. Issuers in state exchanges should be able to adhere to similar time standards.

Accurate provider directories

Secret shopper surveys have demonstrated that provider directories are often inaccurate. Though CMS conducts some review of QHP provider directories in the federal exchange, there should be reviews in all marketplaces.¹³ The No Surprises Act requires that plans and providers regularly update information about providers that participate in the plan (PHSA 2799B-9), and we urge prompt implementation and oversight of this requirement among all health plans and marketplaces.

Substance use treatment

We also urge CMS and states to improve network adequacy standards relating to substance use treatment. Drug overdose deaths continue to be at an all-time high, with nearly 112,000 predicted deaths in 12 months as of June 2023.¹⁴ Opioid and fentanyl death rates continue to be highest for American Indian/Alaska Native men and Black men.¹⁵ The Consolidated Appropriations Act of 2023 enabled more practitioners to prescribe buprenorphine, but these prescribers must still register with the Drug Enforcement Administration and meet its requirements.¹⁶ It is therefore important that marketplace plans specifically have adequate networks of registered substance use treatment subscribers.

It is crucial to our nation's public health that all health plans cover and provide adequate treatment for substance use disorders. For the federally-facilitated exchange, substance use treatment centers are an essential community provider. 2025 draft guidance also lists addiction medicine specialists as a type of behavioral health specialist that must be available without unreasonable delay. **We support that draft guidance and urge CMS and state-based exchanges to adopt rules and procedures to ensure that there are enough providers that specialize in substance use disorder services, including those that are able to prescribe medications for the treatment of substance use disorders.**

Stand-alone dental plans

We also urge CMS to improve standards for stand-alone dental plans (SADPs), and we continue to oppose the limited exception that excuses some SADPs from network adequacy requirements.

Currently, SADPs are exempted from network adequacy requirements if they sell plans in areas where it is "prohibitively difficult for the issuer to establish a network of dental providers"—an exception that is not given to QHPs who are ensuring pediatric dental coverage. While dental provider availability remains a concern, especially in rural areas, we urge CMS to enforce dental network adequacy equally across QHPs and SADPs rather than extending this limited exception to SADPs in SBMs and SBE-FPs. **Further, we urge CMS to pursue policies that aim to close gaps in access to dental providers rather than allowing insurers to avoid responsibility in ensuring access to the services their members pay for.**

Language access and cultural competency, and accessibility for people with disabilities

Future standards for network adequacy should include the measurement of language access and cultural competency, as well as accessibility for people with disabilities.¹⁷ In interviews and focus

groups conducted by Families USA in 2022, participants repeatedly noted the lack of language access and cultural competency as major barriers to health equity.¹⁸

Improving the transparency of key information to improve health care coverage

The Affordable Care Act requires that certain data be available to the public and submitted to federal and state regulators (42 U.S. Code §18031). Included in the code and regulations is the general category, “Information on cost-sharing and payments with respect to any out-of-network coverage.” **However, regulations at §156.220 and guidance should further specify the reporting of the number of providers of various types that are within required appointment time, and within travel time and distance standards; the number of enrollees that could not receive timely appointments of various types within networks; and the number of out-of-network claims by provider type.** This would enable the public to better understand the sufficiency of networks and the extent of out-of-network claims.

Plan member services

Additionally, future rules should delineate health plan member services departments’ responsibility for helping beneficiaries find available in-network providers on request. Witnesses at a May 3, 2023 Senate Finance Committee hearing, “Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks,” explained how problematic it is to find behavioral health providers in plans’ networks: “For people who are experiencing significant mental illness or substance use disorders, the process of going through an inaccurate provider directory to find an appointment with someone who can help them is at best demoralizing and at worst set up to precipitate clinical deterioration and a preventable crisis,” explained Robert Trestman on behalf of the American Psychiatric Association.¹⁹ Various studies have shown that researchers have been unable to make appointments with psychiatrists in plans’ provider directories 74% to 83% of the time.²⁰ California has taken steps to enforce plans’ responsibility in that area: California requires state-regulated plans to arrange coverage with an out-of-network provider if in-network providers are not available to address mental health or substance use disorders within timely access standards.²¹ Additionally, a California Department of Managed Health Care letter to all managed care plans regulated by the state further specifies that in order to arrange coverage, plans must take steps such as contacting a noncontracted provider on behalf of the enrollee to ensure availability, or actually assist the enrollee in scheduling an appointment.²² **Families USA recommends that federal rules for marketplace plans require similar assistance when enrollees are unable to make timely appointments on their own.**

Provision of Essential Health Benefits (§156.115)

Families USA strongly supports CMS’s proposal to remove the regulatory prohibition on issuers from including routine non-pediatric dental services as an essential health benefit (EHB). We believe this is particularly important as oral health care is unaffordable and inaccessible for millions of adults in this country. In fact, dental care presents the highest financial barriers of any health care service²³ – and lack of coverage options exacerbates the considerable racial and income-based disparities in access and outcomes outlined in the proposed rule.

We support CMS’s updated interpretation of statute, which takes a more holistic view of all the benefits typically covered by employers, regardless of whether they are embedded in medical plans or offered as a separate benefits plan. Relatedly, we agree with CMS’s assessment that routine dental care—for adults,

not just their children-- is a commonly covered benefit in employer sponsored insurance (ESI) arrangements and should be included as a covered benefit. This change is an important clarification of the original intent of the Affordable Care Act, which was written to ensure that Marketplace plans align with employer-sponsored plans, and that EHBs include the full scope of benefits typically provided by employer plans. In keeping with this proposed framework, **Families USA recommends exploring similar changes in future rule-making, including the option to cover routine eye exams.**

Ultimately, we continue to urge HHS to embed adult dental services into the ambulatory and preventive services EHB categories. While we applaud the progress this rule represents in providing flexibility for states to offer additional coverage of adult dental services, we remain concerned that the benchmark approach will continue to result in considerable variation in EHB coverage across states and thus inequitable access to critical dental services. We are concerned that relying exclusively on states to take up an optional policy could leave many working age adults vulnerable to the gaps inherent to the current EHB standards, which leave millions of people to pay high out-of-pocket costs²⁴, seek care in emergency departments, where they incur debt, or live in pain because they can't afford the care they need. Given this proposed rule's recognition that non-pediatric dental services are commonly included as a part of typical ESI arrangements, **CMS should fully apply its authority to add adult dental benefits as a required coverage category under Essential Health Benefits in future rule-making.**

We also offer support for several additional provisions in the proposed rule:

- We support the provisions enabling marketplace applicants to attest to their incarceration status (§155.315). This change will save exchanges administrative costs and make it easier for previously incarcerated individuals to access benefits on their release or pending disposition of charges. As noted in the preamble to the proposed rule, few incarcerated people apply for marketplace coverage and it is burdensome for formerly incarcerated individuals to promptly obtain documents. Attestation will help people obtain needed coverage without the delays caused by missing paperwork.
- We support setting the minimum enrollment period for state exchanges as beginning on November 1 of the calendar year ending no earlier than January 15 of the benefit year. State exchanges should have the ability to extend the enrollment period, making it easy to message nationally that marketplace enrollment is open. We agree that state exchanges should continue to have the option to extend this enrollment period to give people additional time to enroll. (§155.410).²⁵
- We support continuous special enrollment for people with income below 150 percent of the federal poverty level (§155.420). This will help the lowest income enrollees maintain coverage when their incomes rise slightly above Medicaid levels. Researchers noted average coverage gaps of 73 days for white adults and 105 days for Black, non-Hispanic adults, moving from Medicaid to the exchange in 2018. The ability to enroll at any time could lessen such a coverage gap.
- We support allowing state public hearings on 1332 waivers to be conducted in an in-person, virtual, or hybrid format. Virtual hearings will make it easier for many members of the public to provide input (§155.1312), and hybrid hearings would accommodate people who may not have digital access or who otherwise wish to be present, along with those who are only able to participate virtually.

- With regard to the proposed changes in §156.202 that would allow issuers to provide additional non-standardized plans if the plans have specific design features that benefit consumers with chronic and high-cost conditions, the information presented in the proposal is insufficient to allow Families USA to take a position at this time. Plan standardization is important to enable consumers to compare plans with similar benefit options, reduce choice overload and ensure that some important services are available with minimal cost-sharing. It is difficult to comment on the addition of these non-standardized plans without more information about the conditions they will address, or the process plan designers will use to gather input from the affected patient community. If this rule is adopted, we request that CMS report on the actual use of the non-standardized plans by consumers with chronic conditions and on how patients' costs differed from the cost burden they would have experienced in standard plans. Such an evaluation would be useful in determining whether these plans should continue and become standardized options.

Thank you for considering these comments. For further information, please contact Cheryl Fish-Parcham, cparcham@familiesusa.org.

Sincerely,



Sophia Tripoli

Senior Director of Health Policy

¹ CMS, "Marketplace 2023 Open Enrollment Period Report: Final National Snapshot," January 25, 2023, [Marketplace 2023 Open Enrollment Period Report: Final National Snapshot | CMS](#)

² Rebecca Myerson, et al, "Personalized Telephone Outreach Increased Health Insurance Take-Up for Hard-to-Reach Populations, but Challenges Remain," Health Affairs, January 2022, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01000>. (See also the studies that this article cites.)

³ Accessed on January 7, 2024.

⁴ Personal information from Deanna Williams, Health Insurance Navigator, Georgians for a Healthy Future, December 7, 2023.

⁵ *ibid*

⁶ Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm, Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes-them-to>.

⁷ Frederick Isasi, Families USA, Comments on Georgia's proposed 1332 waiver, filed September 16, 2020 and available on [Organization comment letters GA waiver Aug Sept 2020 \(cms.gov\)](#).

⁸ Tara Straw, "Direct Enrollment in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," Center on Budget and Policy Priorities, March 15, 2019;

⁹ <https://www.iwebquotes.com/HealthInsuranceQuote.aspx> webpage, accessed January 3, 2024.

¹⁰ Search conducted on <https://www.healthcare.gov/direct-enrollment/> for Georgia and Texas on January 3, 2024, linking to <https://www.iwebquotes.com/HealthInsuranceQuote.aspx>.

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- ¹¹ National Conference of State Legislators, “Health Insurance Network Adequacy Requirements,” updated June 1, 2023, [Health Insurance Network Adequacy Requirements \(ncsl.org\)](https://www.ncsl.org/health-insurance-network-adequacy-requirements) As of 2021, a number of states lacked state quantitative standards for network adequacy that would apply to marketplace plans. Justin Giovanelli, [Ensuring the Adequacy of ACA Marketplace Plan Networks | Commonwealth Fund](https://www.commonwealthfund.org/publications/issue-briefs/2022/feb/15/ensuring-the-adequacy-of-aca-marketplace-plan-networks), Feb 15, 2022.
- ¹² For example, DC finalized network access and adequacy standards for its regulated plans on Feb 17, 23 that will go into effect Jan 1, 24. Rules had been proposed first been proposed in 2017, then a proposal was revised and reissued before adoption. DC Municipal Regulations and District of Columbia Register, Section 26-A4703, Network Adequacy, available on [Search - DCRegs](https://www.dcregistry.com/search).
- ¹³ GAO, State and Federal Oversight of Provider Networks Varies, December 2022, <https://www.gao.gov/assets/gao-23-105642.pdf>.
- ¹⁴ National Center for Health Statistics, “Provisional Drug Overdose Death Counts,” based on data available on November 5, 2023, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.
- ¹⁵ KFF, Opioid Overdose Deaths by Race/Ethnicity, 2021, <https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; Beth Han, et al, “Racial and Ethnic Disparities in Drug Overdose Deaths in the US During the COVID-19 Pandemic,” JAMA, September 20, 2022, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796547/>
- ¹⁶ Substance Abuse and Mental Health Services Administration, “Waiver Elimination (MAT Act)” webpage, accessed December 11, 2023, <https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act#:~:text=All%20practitioners%20who%20have%20a,permitted%20by%20applicable%20state%20law.>
- ¹⁷ Karen Pollitz, “Network Adequacy Standards and Enforcement,” KFF, February 4, 2022, <https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/>.
- ¹⁸ Fish-Parcham, et al, “Community Voices: Recommendations To State Policymakers For Advancing Health Equity”, Families USA, March 2022.
- ¹⁹ Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks, May 3, 2023, <https://www.finance.senate.gov/hearings/barriers-to-mental-health-care-improving-provider-directory-accuracy-to-reduce-the-prevalence-of-ghost-networks>
- ²⁰ <https://www.statnews.com/2019/06/17/ghost-networks-psychiatrists-hinder-patient-care/>
- ²¹ California Code, Health and Safety Code - HSC § 1374.72.
- ²² Nathan Nau, California Department of Managed Health Care, [All Plan Letter](https://www.dmhca.ca.gov/all-plan-letter), December 21, 2022.
- ²³ Marko Vujicic, Thomas Buchmueller, and Rachel Klein, “Dental Care Presents the Highest Level of Financial Barriers, Compared to Other Types of Health Care Services,” Health Affairs, 2016, [Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services | Health Affairs](https://www.healthaffairs.org/content/35/11/e1672).
- ²⁴ Vujicic, op cit.
- ²⁵ MacPac, “Transitions Between Medicaid, CHIP, and Exchange Coverage,” July 2022.