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December 22, 2014

Marilyn B. Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS 9944-P, Patient Protections Care Act; HHS Notice of Benefit and Payment Parameters for 2016, November 26, 2014 (Federal Register Vol. 7, No. 228).***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule establishing the 2016 benefit and payment parameters standards for health insurance issuers and the new Health Insurance Marketplaces. The proposed rule includes recommended changes to a long list of standards, including provisions related to eligibility, enrollment, essential health benefits, qualified health plans, network adequacy, minimum essential coverage, quality improvement strategies and payment parameters, such as risk adjustment, reinsurance and risk corridors.

The AHA appreciates CMS's efforts to fine tune and improve implementation of the insurance provisions in the Affordable Care Act (ACA); continuous evaluation is important to resolve issues quickly as they arise. The AHA supports many of the proposed changes, but several provisions need to be revised. Our detailed comments follow.

### **GENERAL DEFINITIONS (SEC. 144.103)**

**The AHA supports the revised definition of a “plan,” which better distinguishes between a plan and a product line.** A “plan” is now defined as the pairing of the health insurance coverage benefits under the product with a particular cost-sharing structure, provider network and service area. The “product” comprises all plans offered with those characteristics; the combination of the service areas for all plans offered within a product constitutes the total service area of the product. This is a critically important change that will substantially enhance the disclosure and transparency requirements in the rules, providing the public and regulators with the ability to



compare plans more effectively, rather than the current approach of lumping together all of an issuer's plans of a particular type (such as PPOs or HMOs) within a particular metal level (such as Bronze, Silver, Gold or Platinum). For example, it will provide more opportunities to evaluate differences in price, cost-sharing, proposed premium increases, type and size of networks, and performance between plans.

## **EXCHANGE STANDARDS, INCLUDING: ELIGIBILITY, ENROLLMENT AND BENEFITS (SECTIONS 155.205-155.420)**

Our comments below address Marketplace standards for enrollment, re-enrollment and consumer enrollment assistance.

### *Annual Eligibility Redetermination (Section 155.335)*

**The AHA supports an automatic re-enrollment process to ensure covered individuals are not inadvertently left uncovered in a subsequent plan year due to the enrollee's inaction during the enrollment period. We agree with CMS that multiple re-enrollment hierarchies should be made available at the time of initial enrollment. However, we caution that it is critical that these options be limited to two, are easy to understand, and are broadly communicated to enrollees, plans, providers and navigators.**

While ideally consumers would shop each year for a plan that best meets their needs, automatic re-enrollment would help avoid inadvertent loss of coverage due to unforeseen circumstances. In the event that a current plan has significant changes in rates and/or benefits, or is no longer available, re-enrollment hierarchies become critically important for placing enrollees in similar and appropriate coverage.

Given the typical insurance tradeoff between coverage and premium levels, it is difficult to identify a single decision hierarchy that will meet the financial and coverage needs of all enrollees. **For these reasons, the AHA supports CMS's exploration of offering the enrollee an option at the time of initial enrollment on the federally facilitated exchange (FFE) or on a state-based exchange for the priority the enrollee would like to place if an automatic re-enrollment hierarchy needs to be invoked. However, we caution CMS that steps must be taken to avoid confusion for enrollees and navigators and to avoid unnecessary re-work to correct problems after the fact.** Maintaining access to preferred providers is critically important for some plan enrollees, often more important than the premium level, especially for those engaged in ongoing care. **Any set of hierarchies must clearly articulate the options that best ensure the enrollee will retain access to his/her existing providers.** With the growing number of network variations available in many markets, simply maintaining coverage from the same insurer will not guarantee maintenance of network providers. **The option presented for discussion in the proposed rule that places the enrollee randomly in one of the three least expensive qualified health plans (QHPs) within his/her current metal level, leaves the enrollee at great risk of benefit, network and operational changes and is not an acceptable approach.**

*Enrollment in Qualified Health Plans (Sections 155.400-155.420)*

**The AHA agrees that a shorter open enrollment period in 2015 for plans effective Jan. 1, 2016 is best for enrollees and health plans, and will avoid the potential confusion that results from an enrollment period that crosses into the new plan year.** An open enrollment that begins on Oct. 1, 2015 and ends on Dec. 15, 2015 for an effective date of Jan.1, 2016 is consistent with other enrollments that happen for the Jan. 1, 2016 effective date, particularly in Medicare Advantage and the Federal Employee Health Benefits Program (FEHBP), as well as the majority of large employer groups. Given the shorter enrollment window, the AHA suggests that consumers be given the opportunity to shop on the federal and state exchanges beginning before Oct. 1, 2015, even if plan selections cannot be made until Oct. 1, 2015. This will allow more time for consumers to review options and compare plans before having to make a selection. It also will allow more time for consumers to work with navigators and certified application counselors whose capacity may be stretched during an abbreviated enrollment period.

**The AHA also supports the proposal to provide a special enrollment period for individuals living in non-Medicaid expansion states who have become eligible for premium tax subsidies because the individual has a change of income.** This special enrollment period would provide these individuals, with very low income and no access to Medicaid coverage in their state, to gain access to subsidy supported health coverage before the next Marketplace open enrollment period.

*Consumer Assistance Tools (Sec. 155.205)*

**The AHA commends CMS for its efforts to ensure that individuals seeking assistance with enrollment are provided the language and other services necessary for equal access to assistance with enrollment, including basic information and education on insurance basics and their options.**

CMS proposes to expand the standards applicable to exchanges for providing meaningful access to information for people with disabilities or limited English proficiency. Of particular note is the requirement that exchanges and brokers provide oral interpretation in at least 150 languages. CMS has solicited comments not only on its proposed changes, but also on the many recommendations received from interested parties that are reflected in the preamble discussion, including some offered by the AHA on the navigator rules when they were originally proposed.

The AHA and its members are committed to helping uninsured individuals enroll in health coverage. America's hospitals play a vital role in their communities, providing not only access to needed health care services but also connections to health care coverage. Providing consumer education and assistance about the benefits of the ACA, as well as coverage and financial assistance options available to low-income individuals and families, requires an "all-hands-on-deck" approach combining as broad a cross-section of stakeholders as can be mustered. This was amply reinforced last year during the first open enrollment period. **That is why the AHA continues to support the provision of such assistance in the most efficient and flexible way possible by allowing assisters to provide such services directly or through referrals, especially for those who provide assistance to consumers on a voluntary basis, without financial assistance.** We do not wish to see any disincentives for hospitals or others to lend their hands to the task of enrolling individuals in health coverage.

**The AHA believes the following hierarchy would meet these goals:**

- The federal government should make written translations of key consumer communications and application forms available in as many languages as possible in a centralized location on its website.
- All exchanges should fully meet equal access requirements, using a variety of internal and external services as needed by those seeking enrollment through their exchange – in other words, exchanges should not be able to refer to others.
- Paid assisters, including brokers, agents, navigators and others, should be expected to provide language and physical accessibility services for prevalent languages in the community, referring unusual needs to the exchange operating in their state when they lack the resources to do so.
- Voluntary assisters should be expected to use their existing in-house capabilities, but should not be compelled to purchase services from an outside source. It should be their option whether to voluntarily fund the services or refer the individual to local paid assisters or the exchange operating in their state.

**HEALTH INSURANCE ISSUER AND HEALTH INSURANCE MARKETPLACE STANDARDS (SECTIONS 156.115-145)**

Essential Health Benefits (EHB) standards are important in helping to determine whether health plan coverage is meaningful, responsive to individuals' needs and easily understood. The following comments address key provisions within the EHB standards.

*Minimum Value (Section 156.145)*

**The AHA is pleased that CMS addressed our significant concern that employers with more than 50 employees were able to offer health insurance plans to their employees, beginning in plan year 2015, that lacked sufficient hospital inpatient benefits. These plans still met coverage requirements of the ACA and, thus, allowed these employers to avoid paying shared responsibility payments.**

Large employers are required to offer their employees an affordable health plan that meets or exceeds the “minimum value (MV) threshold” of covering at least 60 percent of expected costs. For example, at 60 percent actuarial value the plan, on average, would expect to pay 60 percent of the costs of care and the employees would pay 40 percent through cost-sharing and deductibles. There are three ways to determine if a plan meets the MV requirements: a MV online calculator developed by the Department of Health and Human Services (HHS), a set of safe harbor benefits, and, as a last resort, certification by a member of the American Academy of Actuaries. The HHS calculator is the primary way plans determine if they meet the MV requirement; the Department of the Treasury is charged with enforcing the MV standard. If an employer fails to offer coverage that meets the MV standard, it must make a shared responsibility payment for each employee that is impacted. While the ACA directed HHS to establish a set of EHBs, including benefits for inpatient and outpatient hospital care, the law does not require employers with more than 50 employees to offer the full range of benefits. Recent reports indicated that plans approved by the online calculator, and therefore certified as meeting

the ACA's 60 percent standard, excluded or had minimal inpatient hospital coverage. Employees offered calculator-approved plans are not eligible to receive subsidies to buy insurance through an online marketplace.

The ACA is supposed to protect all Americans from receiving sub-standard health insurance coverage that leaves them vulnerable to poor health outcomes and potentially disastrous financial stress. Inpatient hospital coverage is critical to the health care continuum and is included specifically in the ACA's definition of EHBs. **We are pleased that CMS responded swiftly with Notice 2014-69 and stopped the proliferation of these types of plans and has now proposed regulations to end the practice permanently. The AHA strongly supports the CMS proposal to amend 156.145 so that plans must not only continue to meet the 60 percent actuarial value standard but must also include "substantial coverage" for both inpatient hospital and physician services. However, we remain concerned that, at this point in time, the term "substantial" remains undefined.**

One way to ensure that coverage is substantial is to assign the benefit a minimum coverage level and an MV standard of its own. More specifically, a benchmark would be established for what services must be covered to be considered substantial, as well as a separate minimum actuarial value as if the benefit were stand-alone. For the former, the AHA suggests using the most popular HMO in the state or the state employee plan as a benchmark for inpatient hospital services. For the latter, to limit unreasonable cost-sharing requirements on enrollees, the actuarial value of the inpatient benefit should at least match the actuarial value of the entire benefit package. This would mean that, if a plan meets the minimum value standard at 60 percent actuarial value, then the inpatient benefit would have to cover at least 60 percent of the projected inpatient costs for the services included in the benchmark. The same standard would hold true for physician services. Since these two benefits represent significant portions of the total benefit package, it is reasonable to require that they not fall below the actuarial value of the total benefit set.

The AHA is disappointed that existing plans that excluded inpatient benefits already had been sold and will remain in force in 2015. Employees of companies that offer such plans are at great financial risk if they need inpatient hospital services during the plan year. **We agree with CMS that these plans do not meet minimum value, even if they achieve the 60 percent threshold, without including inpatient hospital and physician coverage and strongly support CMS's proposal to allow employees who have received these benefit plans from their employers to have access to appropriate benefits and premium subsidies on the exchanges.** We understand that plans without substantial inpatient hospital and physician services benefits sold before Nov. 4, 2014 and in-force before March 1, 2015, will be allowed to remain, and while this is less than adequate coverage under the ACA, we look forward to March 1, 2016 when these plans will no longer be allowed.

*Definition of Habilitative Services (Sec. 156.115)*

**The AHA supports CMS's proposal to establish a uniform definition of habilitative services to be used by states and insurance issuers when a benchmark plan does not include habilitative services.** The proposed definition describes habilitative services as services that "help a person, keep, learn, or improve skills and functioning for daily living." The definition

includes devices provided for a person to attain, maintain or prevent deterioration of a skill or function. It comes from CMS's own Glossary of Health Care Coverage and Medical terms, available on CMS's website (<http://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>). Currently, health plans are allowed to cover habilitation services similar to the rehabilitation services they cover. A uniform definition would: eliminate the option for insurance issuers to establish their own habilitative definition; clarify the difference between habilitative and rehabilitative services; minimize variability; and minimize the lack of coverage for habilitative services. The AHA urges CMS to include the uniform definition in regulation rather than in the preamble of the Notice, as is currently proposed. The proposed rule also would require that insurance issuers impose separate limits in habilitative and rehabilitative services rather than have both types of services count toward the same visit limit. The AHA has long supported a clear definition of habilitative services as critically important for lifelong developmental and health care needs, particularly for children.

*Pediatric Services (Sec. 156.115 (6))*

**The AHA supports CMS's proposed change to require pediatric coverage for an enrollee until the end of the plan year in which the enrollee turns 19 years of age.** This proposed change aligns the EHB standard with the requirement that Medicaid cover children up to age 19 with family income up to 100 percent of the Federal Poverty Limit.

*Prescription Drug Benefits (Sec. 156.122)*

**The AHA supports CMS's alternative proposal to use the drug formulary reference system, American Hospital Formulary Service (AHFS), as the basis for the drug standard for EHB benchmark plans.** Currently EHB plans are required to cover the greater of one drug per United States Pharmacopeia (USP) category or class of the same number of drugs in each USP category and class as the state's EHB benchmark plan. The AHFS is a formulary reference system updated and published by the American Society of Health System Pharmacists. The AHFS has a broader classification of drugs that is more appropriate for the population covered by EHB. USP is primarily a drug classification system for the Medicare population.

**The AHA also supports CMS's proposed changes to the exception process that allows enrollees to access clinically appropriate drugs not covered by the EHB plan.** The proposed change would begin with the 2016 health plan year and would require EHB plans to make a coverage determination within 72 hours after receiving a request for an exception. The proposed change would also require that coverage of the drug be provided for the duration of the prescription, including refills, and that the coverage would be considered EHB for purposes of applying cost sharing limitations. The AHA also supports the proposed recommendation that requires EHB plans to make public an up-to-date and complete list of all covered drugs on its formulary that includes any tiering structure or restrictions. Finally, the AHA encourages CMS to require that issuers temporarily cover non-formulary drugs during the first 30 days of coverage when an individual first enrolls in a plan and is already on a prescription drug regime. This proposed change would provide for greater continuity of coverage for the newly enrolled individual.

*Non-Discrimination (Section 156.125)*

**The AHA supports CMS’s efforts to monitor benefit plan designs that may be discriminatory.** The rule’s preamble uses examples of “questionable” benefit designs including when a benefit that is medically appropriate for all ages is labeled as a pediatric service or when all drugs related to treatment for a specific condition are placed in the highest-cost tier.

*Cost-sharing Requirements (Sec. 156.130)*

**The AHA supports the clarification about cost-sharing for out-of-network services being counted toward out-of-pocket limits, but recommends that HHS go farther than proposed by not leaving it completely at the option of the plan issuer.** The proposed clarification in Sec. 156.130(c) indicates that issuers have the option to count cost-sharing for out-of-network services toward the annual limitation on cost sharing, but are not required to do so. The AHA has long expressed its disagreement with the agencies’ decision allowing plans to not count out-of-network cost-sharing toward annual limits.

With the advent of narrow networks, we are particularly concerned about the potential impact on enrollees in networks developed by insurance companies without regard to the clinical relationships among providers in the service area. We understand the desire of issuers to create incentives for enrollees to use in-network providers and that makes sense when the purpose is care coordination among the providers. However, many narrow networks often are built around low-cost providers, which may or may not meet the needs of enrollees.

**At a minimum, the AHA recommends that where out-of-network services are used because quality in-network services are not available on a timely basis within a reasonable geographic distance or a needed sub-specialty is not available in network, the enrollee should be held harmless financially by treating the services as if they were provided in network.**

## **QHP MINIMUM CERTIFICATION STANDARDS (SECTIONS 156.200 – 156.1130)**

*Network Adequacy Standards (Section 156.230)*

The AHA believes it is important to ensure that enrollees have access to a selection of high-quality providers in or near their communities, while not inhibiting care coordination and the growth of integrated care systems. **The AHA supports the enhancements to network adequacy standards that were contained in the Issuer Letter for 2015 QHPs offered under the federally facilitated exchange, such as notice, disclosure and special enrollment procedures, when significant changes are made to provider networks during or after open enrollment.** We are pleased to see in this proposal that those enhancements will continue to be applied to 2016 QHP applicants.

**The AHA also supports the additional enhancements included with respect to provider directories and the “encouragement” that plans provide a transitional period for new enrollees during which they can continue to receive services from a previous provider not in the new plan’s network if they are in the midst of an active treatment plan, though we recommend that the 30-day limit be changed to 60 days to allow sufficient time to**

**transition care.** We are concerned that 30 days is not a sufficient time for a new enrollee to identify a new in-network physician, obtain an appointment, see that physician and enable a smooth transition from the previous physician to a new physician so that their course of treatment is not disrupted. This is especially the case for treatment by sub-specialists.

With respect to provider directories, we believe the proposed requirements will improve and standardize somewhat the information that will be available to consumers and enrollees. In the preamble, HHS asks for comment on how often provider directories should have to be updated on issuer websites. **The AHA recommends as much standardization of the content of provider directories as possible, the movement toward machine readable formats to enable the development of cross-plan search and comparison functions, and online updating no less often than the first day of each month.** Updates should reflect additions, deletions, changes in a provider's status (such as whether a physician is accepting new patients), and changes in provider affiliations (such as where a physician has hospital admitting privileges). Such network changes should be incorporated in online directories within 30 days of notice from the provider. Plans should not rely solely on provider notice of changes, however. They also should do outreach to providers periodically, especially when providers stop submitting claims to the plan.

Finally, we understand the desire to wait for the revised model state act on network adequacy that the National Association of Insurance Commissioners is developing, but regret that it will then push changes in the federal standards out an additional year to 2017. Given the further delay in significant changes, we urge HHS to continue monitoring for unaddressed problems related to network adequacy.

*Essential Community Providers (ECPs) (Sec. 156.235)*

**The AHA supports CMS's proposed changes to strengthen the ECP standards and have the changes apply to the 2016 plan year.** The AHA believes that QHP issuers must ensure that networks provide both adults and children with access to sufficient numbers and types of health care providers, including ECPs, with experience caring for consumers in low-income families in underserved communities including rural and urban communities.

CMS's proposed rule codifies changes to the ECP standards that were contained in the Issuer Letter for applications to offer 2015 health plans in the federally facilitated marketplaces. These standards require that QHPs must include 30 percent of the ECPs in the plan's service area. This quantitative standard will be updated annually. Also QHPs must include at least one ECP in each of the ECP categories in each county in the service area when an ECP is available. The ECP categories include specific types of health clinics and hospitals. The proposed rule would expand the ECP categories to include ECPs that are state-owned, government and not-for-profit facilities, such as look-alike programs for federally qualified health centers, regardless of whether they receive funds through specific government programs. And finally, the proposed recommendations would allow for an alternative ECP standard for health plans that either employ physicians or provide service through a single contracted medical group. That alternative standard requires that low-income individuals have reasonable and timely access to services.



*Quality Improvement Strategy (Sec. 156.1130)*

Section 1311(c) (1) (E) of the ACA requires QHPs to implement a Quality Improvement Strategy to participate on the exchange. The ACA later defines a Quality Improvement Strategy as “a payment structure that provides increased reimbursement or other incentives...” to improve the health outcomes of plan enrollees, prevent hospital readmissions, improve patient safety and reduce medical errors, implement wellness and health promotion activities, and reduce health and health care disparities. The ACA also requires the Secretary to establish guidelines for Quality Improvement Strategies in consultation with health care quality experts and stakeholders including periodic reporting on activities included in the strategy.

**The AHA is supportive of quality improvement strategies for QHPs offered on the exchanges; however, we urge CMS to incorporate a broad definition of “payment structure” so as to recognize the demonstrated value of quality improvement programs that do not rely on direct financial incentives.** For example, health system-based QHPs that integrate payment and care delivery, often incorporating capitated or shared-risk payment structures, have demonstrated high performance on quality measures through provider alignment and care coordination. The high percentage of integrated provider based systems among five-star Medicare Advantage plans is an example of success in quality improvement for these types of plans. In many cases, these plans have moved beyond fee-for-service based payment and encouraging increases in fee-for-service payments in these models could lead to increased cost without further improvement in quality or reductions in health disparities. Another example of a successful quality improvement strategy is the Hospital Engagement Network, or HEN, project where the AHA, many state hospital associations and a large number of hospitals across the country have been working with grant funding from CMS to tackle very specific quality and patient safety issues, improving quality as well as saving money for the Medicare program. A payment structure could provide funding to engage in specific quality initiatives without necessarily affecting rates paid to providers.

**The AHA believes that CMS’s narrow interpretation of the ACA requirements, by focusing on fee-for-service payment structures primarily, will undermine the current efforts of integrated systems and stymie innovation. The AHA suggests that CMS include other forms of quality improvement incentives, such as shared-risk, capitation and commercial ACOs, among other emerging payment strategies in its evaluation of Quality Improvement Strategies.**

Thank you for your consideration of our comments. If you have any questions, please contact, Jeff Goldman, vice president for coverage policy at (202) 626-4639 or [jgoldman@aha.org](mailto:jgoldman@aha.org).

Sincerely,

/s/

Rick Pollack  
Executive Vice President