

January 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P)

Dear Administrator Brooks-LaSure:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2023.

CMS proposes a number of updates to the rules governing health insurance markets that are intended to improve patients' access to care and experience when shopping for health insurance coverage, as well as support marketplace stability. The AHA supports many of the policies proposed in this rule, including clarifications to the Medical Loss Ratio (MLR) calculations, reestablishment of standardized health plan option requirements, changes to the essential health benefit (EHB) nondiscrimination policy, and new requirements and standards of conduct for agents, brokers and web-brokers. **In particular, we commend CMS on the proposed updates to the network adequacy standards, which are critical to ensuring that patients have access to the care they need. We also strongly support CMS' attention to advancing health equity throughout the proposed polices.** We share this Administration's commitment to dismantling barriers to improving health equity, and we look forward to partnering on this important work.

Our detailed comments on the proposed rule follows.



NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDERS

The AHA greatly appreciates the attention that the Administration is placing on network adequacy, which is critical to ensuring that patients have robust access to the care they need. Hospitals and health systems strongly support network-based coverage where the rules for coverage and out-of-pocket costs are clearly established, and where regulators ensure adequate access points to care.

The AHA has long-raised concerns about the inadequacy of many health plans' networks. The problem has been particularly severe with respect to certain types of services, including behavioral health and post-acute care. In addition, the lack of specific standards for certain types of physician specialties have enabled many plans to effectively not offer comprehensive in-network coverage for many hospital services. For example, the lack of network adequacy standards for specialists, such as emergency physicians and anesthesiologists, have enabled plans to forgo contracting with an adequate number of such providers or, nonsensically, to not ensure that those physicians they do contract with work at the plan's in-network hospitals. In other words: *the plans knowingly fail* to ensure alignment between their contracted physicians and facilities.

Moreover, some large commercial insurers have begun breaching existing network adequacy standards. For example, commercial insurers will contract with a provider or facility, who are then presented to patients as in-network options, only for the insurer to subsequently revoke coverage for many of the services delivered by the provider or facility. These changes generally happen mid-year once coverage has started. These insurers have implemented such policy changes on their enrollees for critical services, including certain outpatient surgeries, specialty pharmacy drug therapies, radiology and imaging. Not only do these policies degrade access to care by effectively narrowing the provider network, they also result in consumers' confusion about their benefits, disruptions to patient-provider relationships and higher out-of-pocket costs for enrollees who continue to seek care at their preferred *in-network* providers.

Such policies fly in the face of the important new consumer protections established by the No Surprises Act. The No Surprises Act was passed to reduce instances where patients face unexpected medical bills because they received care from an out-of-network provider either as a result of an emergency or because they could not have been expected to reasonably know the provider's network status. However, the No Surprises Act will not protect enrollees subject to the aforementioned mid-year coverage changes because the plan continues to technically consider the provider to be "in-network."

These egregious actions restrict patient access to care and create substantial complexity and confusion for both patients and providers. This drives AHA's

strong support for CMS' efforts to strengthen the network adequacy standards for marketplace plans, as well as oversight to ensure plans meet these standards.

We understand that additional details of network adequacy standards will be borne out in future rulemaking; we look forward to continued opportunities to help craft the right set of policies to ensure patients' access to care. We also recognize that nationwide workforce shortages, especially in behavioral health and pediatric care, as well as deficiencies in the availability of data and analytic capabilities, make it challenging to ensure that networks sufficiently meet enrollees' needs. To that end, we reaffirm our strong support and commitment to building the health care workforce needed to meet the nation's needs.

We note that, with respect to behavioral health, many of our recommendations below align with the principles outlined in the November 2021 report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE)'s Office of Behavioral Health, Disability and Aging Policy. We acknowledge that these principles are based on ideals; however, we believe that CMS has the ability to achieve these ideals with input from stakeholders and appropriate investment. We look forward to working with the agency on this important endeavor.

Time and Distance Standards. CMS proposes to add emergency medicine, outpatient clinical behavioral health, pediatric primary care and urgent care as specialties for which qualified health plans (QHPs) would have to meet time and distance standards. In addition, CMS would broaden the definition of "inpatient psychiatry facility" to include both inpatient and residential facilities. **The AHA supports the addition of these specialties, but requests CMS include additional hospital-based specialists as well and offer clarification regarding behavioral health specialist types.**

We are encouraged that CMS is recommending the expansion of its list of specialty types to include emergency and behavioral health providers. Delineating specialty types for inclusion in network adequacy standards is a critical tool to ensure QHPs meet the objective of the Affordable Care Act (ACA), which is to maintain provider networks that are sufficient in number and types of providers and are accessible to enrollees without "unreasonable delay."

We recommend that CMS continue to examine how these standards could be improved by considering further expansions to the specialty list. **We specifically urge CMS to require that QHPs contract with a minimum number of other hospital-based specialists, such as anesthesiologists.** In addition, we urge CMS to consider for future rulemaking more specific pediatric network adequacy standards to ensure that children can get timely and age-appropriate care (physical and mental health) for all levels of complexity.

We also request additional clarification as to what is included in "outpatient behavioral health" beyond "licensed, accredited, or certified professionals."

Outpatient behavioral health professionals include a wide range of subspecialists with varying areas of expertise. We understand why CMS uses the term “behavioral health” to refer to both mental health and substance use disorder; however, for the purposes of defining network adequacy, we believe that these two concentrations should be differentiated and explicitly listed. For example, a network that includes a hospital offering an outpatient eating disorder clinic would not be “adequate” for an enrollee seeking medication-assisted therapy for opioid use disorder.

Similarly, contracting with “certified” professionals does not ensure that those providers are certified in subspecialties needed in the enrollee population or community; a psychiatrist without expertise in pediatric mental health may meet technical standards but would still leave a gap in services.

Ideally, QHPs would use data on enrollee characteristics, such as quantitative information from claims describing utilization and diagnostic patterns, as well as qualitative information similar to that found on hospital community health needs assessments. This would help determine, generally, how, when, where and with whom enrollees seek care. We realize this is a major undertaking, albeit one that we believe is possible.

CMS should, at the very least, hold insurers to time and distance standards to ensure access to basic categories of services including adult psychiatric care, pediatric psychiatric care, substance use disorder treatment including medication-assisted therapy and crisis stabilization services. By covering these bases at a minimum, enrollees would at least be able to access care for critical needs while working with the plan to identify other options for appropriate subspecialty care.

Appointment Wait Times. CMS proposes to adopt appointment wait time standards for a short list of critical service categories: behavioral health services, primary care (routine) and specialty care (non-urgent). **We again recommend that CMS provide additional specificity to the provider/facility type to which appointment wait time standards would apply.**

Network Adequacy Reviews. CMS proposes to evaluate the adequacy of provider networks of QHPs offered through the federally facilitated exchange (FFE), or of plans seeking certification as FFE QHPs (with certain exceptions), beginning with the 2023 plan year. While previous rulemaking deferred adequacy reviews to states with “sufficient” review processes, recent legal action reversed the elimination of the federal government’s reviews. **The AHA supports this proposal, as it is more likely to lead to consistent interpretation and evaluation of compliance with standards.** Leaving these reviews to individual insurance commissioners in states that do not perform plan management functions leaves too much opportunity for confusion and insufficient oversight.

CMS proposes to conduct post-certification compliance reviews in response to access to care complaints, as well as a result of random sampling. If QHPs are unable to meet time, distance and appointment wait time standards, they would be able to submit a justification to account for variances. **We recommend that CMS adopt additional proactive monitoring strategies in addition to reactive compliance reviews.** These might include secret shopper exercises to determine appointment availability, as well as surveys of plan enrollee. Reviews should include comparisons of networks against a comprehensive list of services, as well as claims or utilization analysis to assess provider capacity.

As previously noted, we recognize that workforce shortages in certain specialties or geographies can contribute to the challenge of establishing robust networks. We see robust monitoring of provider networks as an important tool to identify general gaps in access that could inform future network design and workforce policy. For example, the aforementioned ASPE report suggested comparing the utilization of covered behavioral health services with emergency department visits for behavioral health crises, with crisis services usage and jail volumes serving as indicators of insufficient access to routine behavioral health care. By monitoring trends in utilization, CMS can inform policy to improve access beyond alterations to network adequacy standards.

Telehealth Services. CMS proposes to require insurers to submit information about whether network providers offer telehealth services during the certification cycle, beginning with the 2023 plan year. The agency emphasizes that, at least for the first plan year, the data would be for informational purposes only, and used to help inform future development of telehealth standards. The information would not be publicly displayed, and insurers should not interpret this requirement to mean that any telehealth services available in their network should be counted in place of in-person services for the purpose of meeting network adequacy standards. CMS also requests comment on how it might incorporate telehealth availability into network adequacy standards in future years.

The AHA recognizes the value in collecting this information to better understand this important factor of network design. However, we note that any new data collection and reporting requirement inevitably comes with an increase in administrative burden. We urge the agency to consider ways to ensure that the responsibility to collect and report such data is held by insurers and to minimize burden on all parties.

As the experience of the past two years of the COVID-19 pandemic has demonstrated, telehealth services can be a crucial access point for many patients and can extend the reach of providers to fill gaps in care, enhance patient and clinician safety, and support continuity of care. However, the reliance on virtual care during this time has also exposed the depths of the “digital divide,” with significant proportions of the population unable to access care via telehealth modalities due to lack of equipment, broadband internet, or technological knowhow. Thus, we are eager to see findings related to the

types of programs and services being offered virtually, the types of practitioners providing these services, and the types of patients using them, as compared to in-person care. The two sides of the telehealth explosion have been particularly relevant for behavioral health, so we encourage CMS to pay close attention to the specific behavioral health services offered via telehealth.

As the agency considers whether and how to incorporate telehealth availability into network adequacy standards, we suggest CMS consider whether telehealth capacity is an accurate metric for network adequacy and capable of replacing in-person care. Before and during the pandemic, telehealth has served as an important function of provider availability to augment or replace in-person services where appropriate. However, network adequacy requires the availability of a physical network of providers to take care of all patient needs, and we do not yet know how telehealth providers and services contribute to that network. We also do not know how the agency would evaluate the amount of capacity in a telehealth network; without that information or ability, it is difficult to see how network adequacy standards would incorporate telehealth availability.

The Medicare Advantage approach to incorporating telehealth into the assessment of network adequacy offers insurers a “credit” towards meeting time and distance standards: plans that contract with certain types of telehealth providers must only prove that 80% of enrollees reside within the required time and distance standards, as opposed to 90%. This method only is appropriate if those certain types of telehealth providers are accessible to the enrollees who need them. By automatically applying this 10% credit, CMS runs the risk of allowing insurers to “dilute” their market with virtual providers who may not actually have capacity to take on patients, while simultaneously reducing their in-person footprint.

If CMS were to consider this “credit” approach for QHPs, **we would recommend that they apply capacity standards to telehealth providers in a similar way to in-person providers**; that is, in order to consider a provider to be part of the network, that provider must be accepting new patients and offer specified services within a certain number of days.

Essential Community Providers (ECPs). AHA has long held that insurers offering QHP must ensure that networks contain sufficient numbers and types of health care providers, with locations convenient to, and experience caring for, adults *and* children in lower-income families, along with historically marginalized urban and rural communities. QHPs are required to have a sufficient number and geographic distribution of such providers in their networks. CMS proposes three changes to the ECP policy: (1) QHP networks would be required to have 35% (up from 20%) of the available ECPs in each plan’s service area; (2) QHPs would be permitted to demonstrate that they include at least one ECP in each of five specific categories and one in the category of “other” through a contract with a behavioral health provider; and (3) for QHPs using tiered networks, only ECPs that are contracted within the network tier with the lowest cost-

sharing obligation would count toward the minimum percentage requirement. Lastly, CMS seeks comment on whether the newly established Medicare provider, Rural Emergency Hospitals (REHs), should be added to the ECP list of providers.

The AHA supports raising the minimum percentage of ECP providers to 35% percent from 20%. Considering the importance of behavioral health, particularly to the population served by ECPs, we urge CMS to add behavioral health providers as their own ECP category rather than including them in the “other” category. As proposed, QHPs could meet the requirement of including an “other ECP” in their network by including a behavioral health provider, but they are not required to (i.e., they can meet this requirement by including a different type of provider instead). This addition would ensure that these populations have access to at least one behavioral health provider.

With regard to adding REHs to the list of ECP providers, the AHA strongly supports this recommendation. Congress established the REHs as a new Medicare provider type to allow a rural hospital to discontinue most or all of its inpatient capacity while continuing to provide emergency and certain outpatient services and thus remain as access points for care in their communities. As such, REHs clearly meet the intent of ECPs and should be included in the list of providers.

Tiered Networks. For plans with tiered networks, CMS proposes to only count towards meeting network adequacy and ECP standards those providers within the tier with the lowest cost-sharing obligation. **We support this proposal.** While tiering can be a useful tool when used appropriately to help guide patients towards high value providers, some plans implement the process in ways that limit patient access to care, introduce substantial enrollee confusion about their health plan benefits, and can expose patients to unexpected costs. We point back to our earlier example where the largest commercial insurer in the country threatened to move many in-network providers into a higher cost-sharing tier (including a questionable zero-coverage tier) if those in-network providers were unable to meet unilaterally-imposed, mid-year rate cuts. Only counting providers in the lowest cost-sharing tier towards network adequacy and ECP requirements will help ensure that enrollees truly have adequate access to sufficient providers with optimal cost-sharing benefits.

Interaction with No Surprises Act. We appreciate CMS’s awareness of issues “where in-network emergency physicians are in limited supply or not available at in-network hospitals.” As AHA has explained elsewhere, however, these problems are exacerbated by the unlawful interpretation of the No Surprises Act set forth in the interim final rule, entitled “Requirements Related to Surprise Billing; Part II,” 86 Fed. Reg. 55,980 (Oct. 7, 2021). In fact, contrary to HHS’s suggestion, the interpretation of the No Surprises Act in that interim final rule does not “incentivize” contracting between insurers and providers, nor does it “increase access to in-network providers.”

In the few months since it was issued, the interim final rule has done just the opposite. These proposed network adequacy standards, while beneficial in many respects, do not offset the damage caused to in-network hospitals as a result of the interim final rule's unlawful features, in part because these proposed network adequacy standards do not include many types of specialists that are adversely impacted by the interim final rule.

Unintended Impacts of Stronger Network Adequacy Standards. CMS requests comment on whether there may be risks of finalizing stronger network adequacy standards and raises questions about whether these risks would be balanced by policies restricting certain contracting practices. The discussion in this section is largely one-sided and uninformed. The imposition of any of the suggested contracting proposals would harm, not benefit, patients in these plans.³

All available data underscore the vast market power of commercial insurance companies. American Medical Association data clearly shows commercial insurers' dominance in virtually every market in the U.S.¹ Previous *Health Affairs* studies have underscored that it is the lack of competition among commercial insurers that are responsible for higher QHP prices, not lack of competition among hospitals.²

Moreover, hospital contracting practices, including those referenced in the proposed rule are typically instituted to protect against abusive practices by commercial health insurers that harm both hospitals and patients. After all, it was a large commercial insurer that was sued, and others investigated by the Department of Justice's Antitrust Division, for *requiring* the hospitals with which it did business to accept most favored nations' restrictions intended to stifle competition from other commercial insurers and raise their costs.³

Some contract provisions, tiering for example, are intended to assure the integrity of the kind of value based arrangements that have been vigorously promoted by this and previous administrations as means to reduce costs, improve care and reduce disparities.⁴ However, no value based arrangement where insurers shift some financial risk to hospitals can survive if the commercial insurers are permitted to undermine that arrangement by incenting enrollees to seek care elsewhere.

Simply put, commercial insurers cannot have it both ways, enjoying savings from letting providers shoulder some of the financial risk for caring for patients while simultaneously incenting those same patients to go elsewhere for care.

¹ [Competition in Health Insurance: A Comprehensive Study of U.S. Markets](#). American Medical Association, 2021.

² Jessica Van Parys, "ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than In Areas With More Competition." *Health Affairs*, Aug. 2018. doi: 10.1377/hlthaff.2018.0054

³ Dina Overland, "[Michigan Blues would pay \\$30M to resolve 'most favored nation' lawsuit](#)." *Fierce Health*, Sept. 9, 2014.

⁴ "[Where we stand with APMs: the \(value-based\) beat goes on](#)." *naviHealth*, July 29, 2021.

Likewise, contracts that require commercial insurers to contract with the entire hospital system help to reduce disparities, among other benefits, by preventing those insurers from leaving hospitals in less desirable geographic areas (from the insurer's perspective) out of their network, also known as cherry picking. It is clear that commercial insurers' contracting practices are first and foremost intended to support their own financial interests. Hospitals in a system located in struggling urban areas or sparsely populated rural areas are most likely to be the victim of cherry picking to the detriment of those communities because those populations are most likely to be the least lucrative and the most costly for the insurer.

Even if the contracting restrictions discussed in the proposed rule reduced costs for the commercial insurers – and there is no evidence they do or that any cost savings could possibly outweigh the potential harm to enrollees – there is no suggestion whatever that the commercial insurers would be required to pass those savings on to enrollees. Instead, insurers would most likely pocket those savings as they appeared to do⁵ during the first few waves of the COVID-19 pandemic.

Existing Barriers to Achieving Adequate Networks for Behavioral Health. While it may be outside of the scope of this rule, the AHA would like to take this opportunity to highlight additional policy issues affecting network adequacy. As previously mentioned, we applaud CMS for taking this topic seriously; however, many of the proposed provisions, even if thoughtfully implemented, will fail to provide sufficient access to behavioral health care because of existing deficiencies in the health care system.

Those deficiencies specifically include:

- critical shortages in specialized behavioral health workforce, particularly in providers who can prescribe medication-assisted therapy, psychiatric nurses, pediatric mental health specialists and residential treatment providers;
- stringent and sometimes outdated requirements for licensing, board certification, credentialing and scope-of-practice, which restrict who can participate in networks (for example, peer counselors and other substance use disorder specialists);
- low reimbursement rates offered by insurers, which discourage contracting;
- a lack of data to determine capacity and community needs; and
- the complexity of network participation (for example, overlapping networks and outdated directories) that makes it challenging for providers and reviewers to determine whether capacity exists for new patients.

We encourage the agency to look for ways to address these challenges as it develops specific standards to determine network adequacy in future rulemaking. In particular, we urge CMS to consider how any time, distance and appointment wait time standards it

⁵ Amanda Holpuch, "[Pandemic profits: top US health insurers make billions in second quarter.](#)" The Guardian, Aug. 6, 2021.

develops would be evaluated based on potentially overlapping networks, and incorporate more regular and detailed directory reviews as part of the oversight process.

Network Adequacy Issues for Post-acute Care (PAC). Ensuring access to the four PAC settings (long-term care hospitals (LTCH), inpatient rehabilitation hospitals (IRF), skilled nursing facilities (SNF), and home health (HH) agencies) is also of critical importance for those with a medical need for services uniquely delivered by these providers. We appreciate the rule's inclusion of one of these settings, as well as a set of services commonly provided by PAC providers, in the proposed network adequacy guidelines. **However, we ask for the final rule to confirm whether and the extent to which the proposed network adequacy audit methodology already includes the providers and services when provided by PAC providers – and support their inclusion.**

One PAC setting, SNFs, and several services commonly provided services by PAC providers (e.g., physical therapy, pulmonology services, occupational therapy) are included in the proposed time and distance standards. We also appreciate the rule's confirmation that CMS is willing to consider requiring additional settings and services for mandatory time and distance reviews, and encourage consideration of additional PAC settings. In particular, HH agencies should be added, as they are already deemed an essential setting for Medicare Advantage networks' county-level network adequacy criteria. Further, the value of LTCHs and IRFs in treating medically-complex patients with, and recovering from, COVID-19 demonstrated their unique and important roles in the continuum of care. **As such, we also urge the addition of the LTCH, IRF and HH settings in the final rule's version of Table 18.**

MEDICAL LOSS RATIO (MLR)

The MLR measures the amount of premium dollars that go toward health care services and quality improvement activities and caps the amount that insurers can spend on administrative activities or profits. CMS proposes clarifications to the MLR calculations to ensure that insurers are only counting towards the numerator those expenses truly tied to clinical care or quality improvement. CMS argues that such clarifications are necessary, as they have observed artificial inflation of the MLR numerator in the past, which both reduces any potential rebate amount and degrades the value of the premium dollar for consumers. If finalized, provider incentives and bonuses would be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards to be included in the MLR numerator. In addition, only those expenses directly related to activities to improve health care quality would be included in the MLR numerator. **The AHA believes that the MLR standard is an important tool to ensure sufficient resources are dedicated to patients' access to care and to hold health plans accountable for how premium dollars are spent. As such, we support the proposals to clarify how provider incentives and quality improvement activities are treated in MLR calculations.** However, AHA requests clarification on several points.

First, we want to confirm with CMS that alternative payment model (APM) contracts and resulting distributions to providers are still within the contemplated categories of MLR numerator expenses. **We urge CMS to make clear that payments made based on good-faith alternative payment model agreements are not the focus of this proposed rule.** In addition, providers face quality gates in many APM contracts that are intended to justify shared savings payments for purposes of inclusion in the MLR numerator. We further request that CMS clarify that shared savings payments tied to total cost of care performance metrics are sufficient to justify inclusion in the MLR numerator without being additionally tied to quality metrics.

We share CMS' concern about payments meant to inflate reimbursement to providers under the same parent holding company as the insurer. We agree that this could result in the insurer being able to enrich the parent company at the expense of patients and avoid paying consumer rebates. We strongly urge much greater oversight of insurance companies that own (or are owned by) companies that also own networks of providers and other health care services.

In general, we are greatly concerned about the ways in which vertical integration within some of the largest insurers are channeling more health care dollars to their own provider groups and other health care services, often at patients' expense. For example, the marketing materials for one insurer's high-deductible health plans (HDHPs) products may include fine print encouraging enrollees to purchase a health savings account through one of its sister companies. As we discuss in more detail below, we have substantial concerns that HDHPs are frequently marketed to individuals and families who cannot afford the associated cost-sharing, effectively creating a barrier to care.

This vertical integration also may enable plans to engage in other MLR "workarounds." For example, we understand that health plans may be able to count some or all of their utilization management functions in the numerator of the MLR under the category of "quality improvement." We are deeply concerned that while some utilization management programs may support quality and care coordination objectives, many plans have abused these functions to the point that they have a net negative impact on patients by serving as barriers to care. Inappropriate use of utilization management tools, such as prior authorization, has eroded coverage for patients and added significant administrative burden to the health care system. Patients are often forced to endure care delays and deal with the stress of not knowing whether their insurer would apply the coverage for which they have paid as a result of these programs. The extensive approval process that physicians and nurses must navigate, as recent studies have shown, adds billions of dollars to the health care system, contributes to clinician burnout and detracts from patient care.⁶ **We urge CMS to review how insurers are**

⁶ Shrank, W. et al., "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA: The Journal of the American Medical Association. October 7, 2019; National Academies of Medicine, "[Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being.](#)" Oct. 2019.

categorizing their utilization management expenses and set clear guardrails around when, if ever, such activities can be categorized as quality improvement activities.

STANDARDIZED QHP OPTIONS

CMS proposes to require insurers offering plans on the FFE and state based exchanges utilizing the federal platform (SBE-FP) to also offer standardized QHP options at every product network type and metal level and in every service area where they offer a non-standardized option. Related to this proposal, CMS proposes to differentially display the standardized options on healthcare.gov. CMS argues that these changes will enhance the consumer experience, increase consumer understanding and simplify shopping for coverage.

The AHA supports the reintroduction of standardized QHP options and the differentiated display. We agree with CMS on the importance of simplifying the shopping experience for health plan coverage. As we discuss in more detail below and CMS discusses in this rule, consumers often chose plans that may not be in their best interest due to lack of clarity around what they are choosing and their potential cost exposure beyond their monthly premiums. This issue is exasperated when there are so many plans available that it becomes exceedingly challenging to compare all options. Having a robust choice among coverage options is certainly preferable to too few options as it allows consumers to find plans that meet their specific needs, for example, including certain providers in-network and coverage of specific prescription drugs. However, too many plan options can create difficulties for consumers, especially those with lower health literacy, to navigate and make comparisons. **We support CMS's focus on policies that facilitate more meaningful consumer choice, including by exploring stronger meaningful difference standards.** While we believe there is merit to considering whether the exchange should limit the number of plans sold, we urge caution on this approach. Such limits would need to be carefully weighed as they could result in unintended negative consequences, such as forcing consumers out of their existing plans, stymying new health plan entrants, and reducing the availability of high quality, meaningfully different plans.

In the rule, CMS also proposes a methodology for designing the standardized plans, including the cost-sharing parameters and other plan design features. Of note, the proposed standardized plans have greater pre-deductible coverage than the most popular QHPs on the FFE and SBE-FP platforms in plan year 2021. The methodology also supports copayments over co-insurance, though several services, such as emergency room services and inpatient hospital services, would still have co-insurance rather than copayments in the bronze, silver, and gold plan levels.

The AHA appreciates that these proposals begin to put in place plan design and cost-sharing reforms for which we previously have advocated. We are deeply concerned with both the amount and the complexity of patient cost-sharing. Patients

regularly struggle to understand their health plan benefit structures and the resulting uncertainty can result in patients avoiding care. Patients often express confusion to hospitals and health systems around how their coverage works, including which costs apply towards their deductibles and the interaction between point-of-service copayments, co-insurance and deductibles. This leaves patients uncertain about what is covered and what they may owe, which leads to hesitancy about seeking care at all.

Health plan benefit designs that include more services pre-deductible and rely on copayments (rather than coinsurance) help ease patients' financial exposure and make it clearer what they may owe for care. We believe the standardize plan options proposed in this rule will benefit consumers by making their coverage easier to understand and use, as well as better enable them to compare across plans, and therefore support finalizing this proposal.

ESSENTIAL HEALTH BENEFITS (EHB)

CMS proposes several important changes to the EHB requirements, including refining the EHB nondiscrimination policy to clarify that EHB plan design must be based on clinical evidence. CMS includes several examples that it has seen in the past of presumptively discriminatory benefit designs which may steer certain individuals away from a particular health plan. These examples show how benefit design can discriminate against enrollees based on age, health conditions and sociodemographic factors, and makes clear that such discrimination is prohibited. CMS also discusses discrimination through adverse tiering of prescription drugs for chronic health conditions and through service delivery model (i.e., incentivizing telehealth over in-person care).

The AHA supports the proposed changes to the EHB nondiscrimination policy. In particular, we appreciate that CMS plans to monitor how health plan designs that incentivizes telehealth over in-person care may disadvantage certain populations and agree that any plan design that encourages the expansion of virtual care does so in a nondiscriminatory manner.

In addition, CMS proposes to withdraw the flexibility for states to substitute benefits between EHB categories as finalized in the Notice of Benefit and Payment Parameters for 2019. The AHA previously expressed⁷ a number of concerns with the impact of this policy on patients, noting that it could result in patients facing higher out-of-pocket costs for services no longer covered and forcing patients to delay or forgo care based on the high cost. **While we recognize that no state ever requested to use this flexibility, we support CMS withdrawing the policy.**

AGENTS, BROKERS AND WEB-BROKERS

CMS also proposes new requirements for and increased oversight of agents, brokers and web-brokers in order to address behaviors that, according to CMS, adversely affect

⁷ [AHA to CMS re: Proposed Notice of Benefit and Payment Parameters for 2019](#), Nov. 27, 2017.

consumers in the name of greater profits. If finalized, web-brokers would be held to new display standards that offer clear, consistent and consumer-friendly information about the plans sold on the websites, as well as information on how the plans are organized on the site and the rationale behind any type of recommendation or QHP ranking. Web-brokers also would be barred from advertising QHPs or offering preferred placement for a fee. These policies help those searching for coverage become better informed consumers by ensuring that they receive the same type of information about QHPs regardless of where they go to shop, understand the basis for any QHP recommendation, and are not inappropriately steered towards certain plans based on broker compensation. CMS also proposes to revise the standard of conduct for agents, brokers and web-brokers in order to formally ban certain activities, such as enrolling consumers in QHPs without their knowledge, and enhance enforcement of these standards.

The AHA supports the proposed requirements and standards of conduct for agents, brokers and web-brokers. Though we are supportive of multiple avenues for consumers to shop for and purchase health insurance coverage, we have long been concerned⁸ about web-broker activities that may result in inappropriate steering of consumers. **These policies are a good start to better ensure consumers are getting accurate and complete information about QHPs, and we urge the agency to go further in future rulemaking to also restrict the inappropriate steering towards and marketing of sub-standard coverage.** Without further rulemaking, we are concerned that web-brokers can push non-QHPs that pay a higher commission, resulting in consumers unintentionally forgoing premium assistance or public programs that they are eligible for and enrolling in plans that are not comprehensive and do not provide the same level of consumer protections.

NONDISCRIMINATION BASED ON SEXUAL ORIENTATION AND GENDER IDENTITY

In 2020, CMS revised earlier regulations that prohibited discrimination based on sexual orientation or gender identity. At that time, AHA urged CMS not to finalize those proposed changes. AHA explained that narrowing the regulations' protections against discrimination based on sex – including gender identity, sexual orientation, and sex stereotypes – could have an adverse impact on individuals' access to care and health.

AHA supports the current proposal to restore prohibitions against discrimination based on sexual orientation and gender identity under existing legal authorities. Hospitals and health systems value every individual they have the opportunity to serve and oppose discrimination against patients based on characteristics such as race, national origin, religion or sex, including gender identity or sexual orientation. A cornerstone of hospitals and health systems' mission is a commitment to diversity, inclusion, and health equity.

⁸ [AHA to CMS re: Proposed Notice of Benefit and Payment Parameters for 2022](#), Dec. 30, 2020.

AHA shares CMS's view that "prohibiting discrimination based on sexual orientation or gender identity can lead to improved health outcomes for this community, and that the removal of such protections in the 2020 section 1557 final rule frustrated not only guaranteed availability requirements, but also the broader aim of improving health equity." To achieve the shared goal of a healthier society, the health care system must ensure that it can be meaningfully accessed by the entire community. The proposed rule helps achieve that important goal. **The AHA therefore urges that this proposal be finalized.**

RISK ADJUSTMENT

CMS proposes additional technical refinements to the risk adjustment models in order to increase the overall predictive validity of the models and adjust for the impact of data outliers. These changes follow recent technical papers published by CMS on possible model changes and a summary of results of a transfer simulation showing the expected effects of the model changes. **The AHA supports continued refinement of these models to improve predictability and decrease variation in relative risk.** Risk adjustment continues to be important to the strength and stability of the marketplaces, and we appreciate CMS's ongoing attention to program refinements. As CMS continues to update these models, we recommend CMS continue to engage stakeholders to inform future changes.

QUALITY IMPROVEMENT STRATEGY STANDARDS

CMS proposes to update the quality improvement strategy standards in order to require insurers offering QHP to address issues related to disparities in health care outcomes and access. **The AHA applauds the agency on their health equity focus and supports this change to the quality improvement strategy standards.** The AHA is committed to advancing health equity and addressing issues related to health care access. We are working hard to provide our members the necessary tools and resources to ensure they are well positioned to advance and expand their equity work. We look forward to partnering with CMS on this critical work.

SPECIAL ENROLLMENT PERIOD VERIFICATION

CMS proposes to only conduct pre-enrollment verification for special enrollment periods (SEPs) that are the result of a new consumer losing their minimum essential coverage. In the proposed rule, CMS notes that they are proposing this change to minimize burden on eligible consumers while maintaining program integrity. This can be done by focusing on the type of SEP that accounts for the majority of SEP enrollment and allows for auto-verification through electronic data sources. **The AHA supports this change to SEP pre-enrollment verification.** As we have commented previously, measures that maintain program integrity while minimizing the level of burden imposed on consumers are in the best interest of consumers and contribute to the financial viability of the marketplaces. We appreciate CMS' commitment to implementing such measures,

and we look forward to working with the agency on this important work. We also recognize and appreciate that this change promotes greater health equity by removing one barrier to access that has disproportionately impacted historically marginalized communities.

PREMIUM ADJUSTMENT PERCENTAGE

In separate guidance, CMS updated the premium adjustment percentage for the 2023 plan year. Based on the updated percentage, the maximum annual limits on cost-sharing in 2023 are \$9,100 for self-only coverage and \$18,200 for family coverage. **The AHA remains deeply concerned that these out-of-pocket limits are unsustainable and leave patients vulnerable to financial hardship.**

Over the last several years, we have raised concerns⁹ that plans with such high cost exposure leave patients underinsured and unable to afford their care. This harms not only the patient but the financial stability of the hospitals and health systems that serve them. We have heard from our members that more than 50% of charity care is now supporting insured (or rather, underinsured) patients, rather than uninsured patients.

This is why we continue to urge the agency to implement health plan benefit reforms, beginning with HDHPs. These types of products are often marketed – inaccurately – as more cost-effective options for lower income individuals and families. As a result, many people find themselves with health coverage that they cannot use or that subjects them to unexpected medical bills, creating undo financial and emotional stress. We urge the agency to revisit these high out-of-pocket cost limits, as well as consider whether limits should be placed on eligibility for enrollment in high deductible health plans, e.g., demonstration that the consumer is able to meet their cost-sharing limits.

ACTUARIAL VALUE AND DE MINIMIS VARIATION

CMS proposes to limit the de minimis variation of non-grandfathered individual and small group market health plan actuarial values, which were expanded in previous regulations. The new de minimis value would allow most plans to vary by +2/-2 percentage points. CMS argues that this change will increase the premium tax credit amount by increasing the value of the second lowest cost silver plan. It also will reduce the potential for consumer uncertainty regarding the difference between bronze and silver plan coverage, which today may have similar actuarial values. The AHA expressed concern¹⁰ about both the decrease in premium tax credit value and

⁹ [AHA to CMS re: Proposed Updates to Certain Rules Governing the Health Insurance Markets](#), July 27, 2021; [AHA to CMS re: Proposed Notice of Benefit and Payment Parameters for 2022](#), Dec. 30, 2020; [AHA to CMS re: proposed rule on Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage](#), Aug. 14, 2020; [AHA to CMS re: Proposed Notice of Benefit and Payment Parameters for 2021](#), March 2, 2020.

¹⁰ [AHA to CMS re: Proposed Marketplace Stabilization Rule](#), March 7, 2017.

consumer confusion when the de minimis ranges were expanded. **We support CMS in once again narrowing the de minimis range.**

REQUEST FOR COMMENTS ON HEALTH EQUITY AND CLIMATE HEALTH

The increased intensity and effects of extreme climate-related events across our nation is undeniable and the impact cuts across every corner of our country. One primary concern is the impact of climate change on public health. America's hospitals and health systems witness first-hand these public health impacts, ranging from natural disaster-related destruction to increased prevalence of chronic conditions, like asthma, due to poor air quality.

While it is true that climate change impacts everyone, the data/evidence show that the scope and severity of the impact is not equally distributed. Historically marginalized populations suffer its effects much more severely. Factors like the social determinants of health, access to health insurance and other essential resources and levels of exposure all play a significant role in the disproportionate impact.

Simply put, some groups, often times due to circumstances well outside of their control, are affected more significantly than others, and a recognition of that, coupled with corresponding action to develop solutions, is critical to the mission of our members and to the overall health of the country. As such, hospitals and health systems not only have a vested interest in the health of their respective communities, but a responsibility to address their own environmental impact and contributions to climate change.

Given the hospital and health system role in the health care sector's carbon footprint, the AHA, in collaboration with its professional management groups (PMGs), has developed and made available several tools and resources aimed at curbing hospital and health system carbon emissions. These tools include energy assessment programs and immediate, achievable steps that can be taken, as well as longer-term organizational restructuring to de-silo environmental sustainability issues and capital investment considerations.

Through this work, we remain committed to doing our part to reduce hospital and health system carbon emissions, but must be clear: we cannot do this alone. Specifically, the U.S. medical device and pharmaceutical supply chains remain the health care sector's largest contributors to carbon emissions. We stand ready to partner and work with other stakeholders in the health care ecosystem to lower significantly our sector's contributions to climate change.

Moving forward, we support actions aimed at thoughtfully and intentionally reducing overall sector emissions in a manner that does not jeopardize the ability of our members to provide safe and effective care to patients. We are steadfast in our belief that a collaborative approach across the health care sector can significantly lower our contributions to climate change, ultimately creating a safer, healthier environment for all

communities, while also ensuring that the work prioritizes and seeks to close the significant equity gaps that currently exist. Our country is only as healthy as our most needy communities, and the AHA and its members will continue to take steps to meet our communities where they are with the goal of improving public health and providing leadership around environmental sustainability initiatives.

We appreciate the opportunity to comment on CMS' proposed changes in the Notice of Benefit and Payment parameters for 2023. We look forward to continuing to work together to advance health equity and achieve affordable, universal coverage through the framework established under the Affordable Care Act. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, AHA's senior associate director of policy, at 202-626-2335 or alevin@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President