American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

January 30, 2023

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 2024 (CMS-9899-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 2024.

We commend CMS for proposing steps that would enhance access to care for the individuals and families who rely on the Health Insurance Marketplaces (Marketplaces) for their coverage. Specifically, we write in support of the following proposals:

- Designating two critical behavioral health provider types as "essential community providers" (ECPs);
- Designating Rural Emergency Hospitals (REHs) as "Other ECP Providers;"
- Providing more opportunities for navigators and other assisters to enroll individuals in coverage, as well as other changes to ease enrollment, especially in the context of the winding down of the COVID-19 public health emergency (PHE);
- Modifying the requirements related to standardized health plans to support consumers' understanding of their coverage while still allowing plans the flexibility to test different benefit structures; and
- Restricting no-network plans on the Marketplaces.

Our specific comments follow.

Essential Community Providers

The AHA appreciates and supports the proposal to establish two additional stand-alone categories of ECPs to represent mental health facilities and substance use disorder treatment centers, as well as to designate the REHs as "Other ECP Providers." Currently, generic network adequacy standards for types of providers that must be accessible under a qualified health plan (QHP) do not adequately account for needs related to mental health or substance use disorder. Only beginning in plan year 2023 will substance use disorder treatment centers and community mental health centers be added as examples of eligible providers under the major ECP category of "Other ECP providers," meaning that while those provider types are listed as options to fulfill the General ECP standards, QHPs are still not required to offer contracts to behavioral health providers specifically (as long as they offered contracts to a provider of one of the many other types included in the "other" category). The omission of these specific mental health and substance use disorder providers under QHPs leaves a critical gap, one that may remain unaddressed and unenforceable by CMS as these providers' networks would still be considered "adequate" under current standards.

To address this issue, the AHA has recommended that mental health and substance use disorder providers be differentiated and explicitly listed as categories of licensed, accredited, or certified professionals accessible under QHPs. **Thus, we commend CMS for taking steps to ensure that beneficiaries of these plans have access to their essential services.** Even though these categories remain broad — that is, there is no further specification that, for example, child psychiatry or opioid use disorder facilities or providers be included as ECPs — by covering these bases at a minimum, enrollees would at least be able to access care for critical needs from more appropriate specialty care providers.

Similarly, we strongly support CMS' recognition of the critical services REHs will provide in their communities. While this new designation is being implemented for the first time in 2023, we expect that a number of rural communities will rely on REHs as the sole source of a number of higher acuity services in these communities. As a result, we encourage CMS to finalize its proposal to include REHs as "Other ECP Providers," while recognizing that they may warrant their own ECP designation in the future.

Enrollment and Maintenance of Coverage Support

Hospitals and health systems are strong supporters of achieving universal, comprehensive coverage. Comprehensive health care coverage has many benefits for individuals and communities. First and foremost, comprehensive coverage is fundamental to ensuring routine patient access to the full continuum of care. Universal coverage helps ensure adequate health care system financing and affordability for all

payers as costs are shared across the broadest group of people. Therefore, we are deeply concerned about the impending end of Medicaid's continuous coverage requirement made possible because of the COVID-19 PHE. **Therefore, we strongly support the proposals included in this rule specifically intended to help enroll new consumers, including those transitioning off Medicaid or the Children's Health Insurance Program (CHIP), and continue coverage for current enrollees.**

Specifically, we encourage CMS to finalize the following policies, among others in the proposed rule:

- Enabling navigators and other assisters to directly contact unsolicited potential consumers, including by going door-to-door, and allowing for them to enroll those consumers in the moment, as opposed to requiring the consumer to schedule a follow-up appointment. We believe this change could help prevent an eligible and interested consumer from "slipping through the cracks";
- Providing Marketplaces with greater flexibility with respect to auto-reenrollment policies, which a consumer could always override. Again, we believe this policy could prevent inadvertent loss of coverage if the individual or family is confused about the need to reenroll or assumes that they will be auto-reenrolled. We are particularly pleased to see CMS' recognition of provider networks as an important consideration when establishing auto-reenrollment policies;
- Permitting two years (rather than only one) for enrollees to have filed and reconciled their advance premium tax credits, to ensure enrollees do not lose their subsidies and face unexpected tax burdens due to delayed IRS data or lower health coverage literacy;
- Accepting families' attested income, rather than subjecting them to additional IRS verification processes, when the IRS cannot find their data (which generally occurs when family size changes, due to getting married, having a child, etc.);
- Allowing for earlier start dates for individuals and families who have lost minimum essential health coverage; and
- Permitting consumers up to 90 days after loss of Medicaid or CHIP coverage to select a Marketplace plan.

While more must be done to achieve universal and comprehensive coverage, including expanding Medicaid in every state, these proposals take important steps to minimize coverage loss at the conclusion of the COVID-19 PHE.

Standardized Plans

CMS proposes several modest changes to the requirements related to standardized health plans, including limiting the sale of non-standardized plans to two per metal tier and product type in any service area. In addition, CMS considers whether to reinstate a modified version of the meaningful difference standard. In both instances, we understand CMS' intent to reduce the number of plan options that do not offer

meaningful alternatives to one another such that consumers are not overwhelmed by the volume of choices if those choices do not reflect substantially different coverage.

Generally speaking, the AHA supports CMS' intention of reducing any confusion consumers may have about selecting and using their coverage. Hospitals and health systems frequently report patient confusion with their coverage, including what services are covered at what providers and with what cost-sharing obligations. While we fully recognize the value of testing innovative benefit designs and some consumers' desire for more tailored benefit packages, we generally believe that, at this point, more standardization (or a clear requirement to be meaningfully different) is a better approach to improving health care coverage literacy and to ensuring individuals are enrolling in the coverage that best suits their needs.

However, we also recognize that most consumers have selected non-standardized health plan options. **While we believe CMS is attempting to strike an appropriate balance in its proposal to further standardize health plan offerings while also allowing opportunity for issuers to offer alternatives, we encourage the agency to carefully consider the implications this policy may have on changes to an enrollees' coverage.** Specifically, we are concerned that patients may face greater confusion – at least in the short term – if their coverage ceases to exist because of this policy and they are moved into a plan with new and different rules. We believe these concerns may be mitigated by clear enrollee education and urge the agency to ensure plans communicate clearly with their enrollees about any changes in their coverage.

Restricting the Sale of No-network Plans

CMS proposes to restrict the sale of no-network plans on the Marketplaces. While we recognize that some such plans may reflect innovative new ways of delivering coverage, hospitals' and health systems' experience to date with such plans have been generally negative, suggesting that more work needs to be done to ensure they provide adequate patient access to care before they are adopted more broadly. Therefore, we support CMS' proposal at this time while monitoring their evolution in other markets.

No-network plans generally rely on unilaterally-developed reference-based pricing structures to reimburse providers for the services covered by the plan. Specifically, instead of negotiating with a network of providers to ensure access to care for their enrollees, the plan sets a price for each health care service and leaves the enrollee to find a provider that will accept that price. Hospitals and health systems' experience, however, is that patients with these plans often are either unaware of this obligation to shop for services or are unable to find a provider that will accept their coverage. These scenarios can create access challenges for patients, as well as add unexpected costs to their care as they are responsible for any amount above what is allotted for by their plan. And, except for emergency services, the important No Surprises Act protections against balance billing for out-of-network services would rarely, if ever, apply in these

scenarios as there is no network of which a provider could be a part. Hence, we support CMS' proposal to restrict the sale of such plans on the Marketplaces at this time.

Again, we thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Molly Smith, AHA's group vice president of public policy, at mollysmith@aha.org or 202-626-4639.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development