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January 30, 2023

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

Re: Proposed Rule; Patient Protection and Affordable Care Act, HHS Notice of Benefits and Payment Parameters for 2024. Centers for Medicare & Medicaid Services, Department of Health and Human Services (CMS-9899-P)

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the Notice of Proposed Rulemaking on the Notice of Benefits and Payment Parameters (NBPP) for 2024 published in the *Federal Register* on December 21, 2022. The AMA appreciates that the proposed rule would continue CMS recent efforts to simplify consumer choice and improve the plan selection process in the Affordable Care Act (ACA) marketplaces; increase network adequacy requirements and essential community providers (ECP) categories; expand provisions for navigators and other consumer assisters; and establish new rules for agents, brokers, and web-brokers that assist consumers with enrollments. Our comments focus on these provisions. The AMA commends the Administration for its commitment to extending health insurance coverage to more Americans and making it easier and more affordable to get covered.

Standardized Plan Options

CMS continues its approach from the 2023 NBPP to simplify consumer choice and improve the plan selection process in the ACA marketplaces. In last year's NBPP, CMS re-introduced standardized plans (named "Easy Pricing" plans), pursuant to which issuers that offer qualified health plans (QHPs) through the federal marketplaces to offer standardized benefit plans designed by CMS for every product network type, at every metal level, and throughout every service area in which they offer non-standardized plans. Consumers can apply filters on HealthCare.gov to view and compare only standardized plans. The AMA supported these changes.

For Plan Year (PY) 2024, CMS proposes to continue the Easy Pricing plans with a few minor changes. First, issuers would no longer be required to offer a standardized plan at the non-expanded bronze metal level ("expanded" Bronze plans cover at least one non-preventive service pre-deductible or meet the IRS' definition of a high-deductible health plan and are permitted to have an actuarial value of up to 5 points above the 60 percent standard). CMS' rationale for this change is mainly due to actuarial value (AV) constraints; the agency explains that it was not feasible to design a non-expanded bronze plan that

includes any pre-deductible coverage that meets the AV target within the allowable de minimis range. CMS also noted that most issuers in the federal marketplace chose not to offer non-expanded bronze plans. We agree with the agency that this proposed change would minimize burden without any negative consequences, particularly since CMS clarifies that issuers would still be allowed to offer non-standardized plan options at the non-expanded bronze level, thereby giving consumers the ability to choose those plan options.

CMS also intends to continue the use of four prescription drug tiers in its standardized plans, i.e., generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. We agree with the agency that limiting the formulary to these four tiers helps to promote understandable drug coverage and facilitates consumers' ability to compare plan options, but we remain concerned about continuing reports that some issuers are not placing certain drugs at the appropriate cost-sharing tiers. We also remain concerned by long-standing research showing adverse and discriminatory tiering policies from payers that result in patient harm. That is why we support the proposal to require issuers to place all covered drugs in the appropriate cost-sharing tier unless there is an appropriate and non-discriminatory, i.e., clinical, basis for placing the drug in the specialty tier. We also urge CMS to monitor issuers' tiering strategies to ensure that payers comply with this new requirement, especially those issuers that have been the subject of complaints.

Further, the 2024 NBPP proposes to limit the number of non-standardized plans that issuers may offer in the marketplaces to two per product network type and metal level, per service area. This change is based on what CMS sees as a continuing need to reduce the overwhelming number of options consumers face on the marketplaces and would reduce the average number of non-standardized plans available to about three dozen, down from over 100. As an alternative approach to limiting the number of issuers' plan offerings, CMS is proposing to reinstate a "meaningful difference" standard, basically a modified version of what the Obama Administration had introduced in 2015. CMS proposes to group plans by county, issuer ID, metal level, product network type, and deductible integration type, and then evaluate whether plans within each group are "meaningful different" than other plans offered by the issuer, based on differences in deductible amounts, which would have to differ by more than $1000.

The AMA supports the latter alternative. The intent of health insurance exchanges is to provide a patient-friendly market for patients to purchase health insurance, as well as increase the competition among plans based on quality and price. In general, patients must navigate through many health plans to make the right choice that responds to their health care needs and budgetary realities. An issue brief released by the Office of Health Policy of the Assistant Secretary for Planning and Evaluation (ASPE) in December 2021 showed that nearly three-quarters of HealthCare.gov consumers have more than 60 plan options to choose from, and more than a quarter must select from more than 160 different plans. Within a specific metal tier, or even within a particular metal tier and a specific issuer, patients still can still face a high number of health plan options from which to choose. Approximately half of HealthCare.gov consumers have more than 40 plan options in the silver tier from which to choose, with nearly three-quarters having more than ten silver plans available from at least one issuer in their county. The AMA agrees that navigating this wide range of health plan choices available on health insurance exchanges may be potentially difficult and confusing for patients, and therefore we support efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

Annual Eligibility Redetermination (Re-enrollment Hierarchy)

Under the proposed rule, marketplaces would be allowed to modify their automatic enrollment hierarchies for assigning enrollees to plans who do not actively reenroll. Enrollees eligible for cost-sharing reduction

would be assigned to silver plans that have cost-sharing reductions available, if their premiums are not increased, rather than being reenrolled in bronze plans for which reduced cost-sharing reductions are not available. In addition, enrollees who are reassigned and enrollees whose previous plans are no longer available would be reassigned to the plan with the most similar network to their prior plan. The AMA supports these changes.

Network Adequacy and Essential Community Providers

Wait Times

The AMA strongly supports CMS' inclusion of wait time requirements into the measurement of network adequacy. We view this standard, combined with other quantitative standards, as critical to determining if a network can serve the needs of enrollees. Often a network provider may be conveniently located but not be accepting new patients or have appointments available in the timeframe needed given their patient load, and wait time requirements could help a plan and regulator address such access issues. As such, we urge CMS to move forward with implementation of this requirement as quickly as possible. We also urge CMS to consider additional tools to measure compliance beyond insurer attestation, including audits, secret shopper programs, and patient interviews/surveys.

Additionally, as the AMA continues to hear from physicians who are being terminated without cause from health insurance networks, we urge CMS to ensure that plans are not making material changes to their networks during the plan year to promote and ensure continuity of care for patients. This would include changes that terminate physicians from the plan's network or contract changes that make it unattractive or unsustainable for a physician to remain in network. CMS should also monitor network plans throughout the year for their continued adequacy while requiring plans to immediately report changes to the network that may impact access to care for patients.

Essential Community Providers

The AMA strongly supports the 2024 proposed addition of two new essential community provider (ECP) categories, Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers. If finalized as proposed, substance use disorder treatment centers and mental health facilities that would be available on the ECP List would be limited to those facilities identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and/or CMS as providing such services, in addition to fulfilling other ECP qualification requirements. ECPs include those that care for individuals in low-income and/or medically underserved communities and it is important that all communities have affordable, convenient and timely access to evidence-based mental health facilities and SUD treatment centers.

In addition to this ECP proposal, the AMA urges CMS to consider additional ways to expand access to mental health and SUD services in underserved communities, including through network adequacy requirements and mental health and SUD parity enforcement.

Additionally, the AMA supports proposed changes to extend the 35 percent threshold to Federally Qualified Health Centers (FQHCs) and family planning providers. These changes would increase provider choice and access to care for low-income and medically underserved consumers, and with regard to family planning providers, are particularly important in states that have banned abortion services.

Requirements for Qualified Health Plan and Plan (QHP) Variant Marketing Names

CMS proposes to require that QHP and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. This proposal is in response to consumer complaints from numerous states about misleading or deceptive plan marketing names. According to CMS, in PY 2022, there was a significant increase in the number of plan and plan variation marketing names using cost-sharing information and other benefit details on the federal marketplace, which resulted in consumer confusion. The AMA supports this proposed change and agrees with CMS that providing standards to help ensure plan marketing names are clear and accurate will reduce burden and confusion for consumers and on navigators and other assisters who help consumers enroll in marketplace coverage. We also agree with the agency that these changes would promote health equity by reducing the likelihood that consumers might misunderstand or be confused about QHP benefits, especially for those consumers with low health literacy, which is disproportionately experienced among underserved and vulnerable populations.

Special Enrollment Periods

CMS proposes giving marketplaces the option to implement a new rule which would allow consumers up to 90 days after their loss of Medicaid or CHIP coverage to select a marketplace plan. Currently, individuals who lose minimum essential coverage have up to 60 days before and up to 60 days after their coverage loss to select a marketplace plan. CMS also proposes to change current coverage effective date requirements so that marketplaces have the option to offer earlier effective start dates for consumers attesting to a future loss of coverage. The AMA supports these changes and urges CMS to retain them in the final rule.

The proposed Special Enrollment period (SEP) changes intend to mitigate coverage gaps for individuals who lose Medicaid or CHIP coverage and are eligible to enroll in marketplace plans. Even brief gaps in coverage can be disruptive in terms of interrupting necessary services and treatments, medication adherence, continuity of care, and in some cases, higher health care costs when delayed care results in more expensive health care needs. Accordingly, the AMA supports efforts to ensure that individuals determined ineligible for Medicaid or CHIP are seamlessly transitioned to other affordable coverage for which they are eligible. Once the continuous enrollment requirement ends on March 31, 2023, smooth transitions between Medicaid and marketplace plans will be even more critical as potentially millions of individuals are determined ineligible for Medicaid. The proposed SEP changes may reduce—but not eliminate—gaps in coverage for significant numbers of individuals disenrolled from Medicaid who qualify for marketplace plans. To further streamline coverage transitions in the future, the AMA supports automatic coverage transitions that meet certain standards around consent and an ability to opt out and that include targeted outreach and streamlined enrollment mechanisms, which include raising awareness of the availability of premium tax credits and cost-sharing reductions, as well as special enrollment periods.

Standards for Navigators and other Consumer Assisters

CMS proposes to allow navigators and other similar consumer assisters to conduct door-to-door enrollment to consumers. Assisters are currently allowed to do door-to-door outreach, education, and schedule follow-up appointments, but are banned from providing enrollment assistance during the initial contact at the consumers' residence. CMS is now proposing to lift this prohibition. Since the agency has already established safeguards to ensure that navigators and assisters maintain the privacy and security of consumers' information, the AMA supports this proposal. We agree with CMS that making this change

will help lift barriers for consumers who must make follow-up appointments for enrollment assistance and for those individuals who may have mobility issues, may not be able to afford to travel for assistance, or who are immunocompromised.

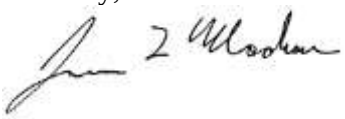
CMS is also proposing new requirements related to agents, brokers, or web-brokers, who would be required to obtain recorded oral or written consent from all individuals they enroll in coverage, as well as document that an applicant reviewed and confirmed the accuracy of eligibility application information has been reviewed and confirmed to be accurate by the consumer prior to application submission. The AMA supports these proposals, which would reduce the possibility that people will be enrolled without their consent.

Co-Pay Accumulator Programs

To offer additional protections for patients with chronic conditions, the AMA urges CMS to prohibit insurers' discriminatory co-pay accumulator policies in the final regulation. Co-pay accumulator programs target individuals in need of specialty drugs (often individuals with chronic and/or complex conditions) who need assistance to meet their financial obligations under their health plan. Co-pay assistance often is the only way that patients with chronic conditions can afford their medication and co-pay accumulator programs prevent patient access by denying them any financial relief from insurmountable cost sharing obligations. These policies also reduce the value of premiums paid by patients with chronic conditions by allowing health plans to "double dip" and accept both the co-pay assistance obtained by the patient and the additional cost-sharing then paid by the patient before the patient reaches their out-of-pocket limits. This exposes these patients to ongoing charges for their prescription drugs as well as any other health care coverage they (or their families) may need during the year. As such, we urge CMS to prohibit co-pay accumulator programs in the final rule.

Thank you for considering the AMA's comments. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,



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