AMA AMERICAN MEDICAL ASSOCIATION

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January 8, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposed Rule; Patient Protection and Affordable Care Act, HHS Notice of Benefits and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program (CMS–9895–P)

Dear Secretary Becerra:

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 U.S. Department of Health and Human Services (HHS) on the Notice of Proposed Rulemaking on the Notice of Benefits and Payment Parameters (NBPP) for 2025 published in the Federal Register on November 24, 2023. The AMA appreciates that the proposed rule would continue HHS' recent efforts to increase access to health care, simplify consumer choice, increase network adequacy requirements, ease enrollment, increase consumer protections, set new standards for state-based exchanges, and adjust the process and standards for essential health benefits (EHB). Our comments focus on network adequacy, enrollment periods, and EHB.

Network Adequacy Requirements

The AMA strongly believes all patients should have the right to access in-network care within reasonable distances and timeframes, regardless of coverage type. Generally, we believe that state regulators should have flexibility to regulate plans' provider networks in their state. However, because many states have not updated their network adequacy requirements, especially in light of narrowing networks, the AMA has long advocated for the establishment of a strong national floor of quantifiable standards.

Accordingly, the AMA strongly supports provisions in the proposed rule that would expand some network adequacy requirements that currently apply to plans offered on federally-facilitated exchanges (FFEs) to issuers participating in state-based exchanges (SBEs) and state-based exchanges on the federal platform (SBE-FPs), including time and distance standards and quantitative network adequacy reviews. We also strongly support the provision stating that, if a state exchange fails to comply with these standards, HHS could seek to take remedial action under its authority related to exchange program integrity.

Time and Distance Standards

The AMA has long supported time and distance standards, which we agree are important quantitative measures of network adequacy. Consistent with policy, **we strongly support HHS' proposal to require that SBEs and SBE-FPs establish and impose quantitative time and distance standards that are at least as stringent as the time and distance standards established for Qualified Health Plans (QHPs) offered in FFEs.** We additionally urge HHS to require QHPs offered in both SBEs and FFEs to consider the needs of enrollees who rely on public transportation in the development of such standards.

As requested in previous comment letters, **we ask that HHS separate outpatient clinical behavioral health into outpatient clinical mental health and outpatient treatment substance use disorder for measurement under Table 10 (Individual Provider Specialty List for Time and Distance Standards) to ensure timely patient access to appropriate providers in their communities.** Failure to differentiate between these two distinct behavioral health care provider types could result in networks being inadequate to meet the specific needs of enrollees who struggle to find in-network mental health and/or substance use treatment providers who are accepting new patients in a timely manner. Notably, network inadequacy combined with high-cost out-of-network care are among the key reasons why individuals with a mental illness or substance use disorder do not receive care. Given that drug-related overdoses and deaths continue to increase, and the mental health needs of the population have multiplied since the COVID-19 pandemic, adequacy of QHP provider networks for outpatient mental health and substance use disorder providers remains critically important.

Quantitative Network Adequacy Reviews

HHS is proposing that state exchanges and SBE-FPs be required to conduct quantitative network adequacy reviews prior to QHP certification, and that they conduct them consistent with the requirements for reviews conducted by QHPs offered in FFEs. Given the proliferation of marketplace plans with narrow networks, as well as studies demonstrating varying degrees of challenges facing enrollees trying to access in-network providers, most commonly for mental health care, **the AMA supports this provision which will hold QHPs in all states to the same standard. We also strongly support HHS' proposal to prohibit SBEs from accepting an issuer's attestation as the only means for plan compliance with network adequacy standards.** Consistent with our policy, the AMA supports moving beyond insurer attestation and requiring the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys/interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy and to identify other access problems.

Wait Times and Other Network Adequacy Standards

The AMA is disappointed that HHS is not proposing to require that state exchanges enforce federal appointment wait time standards for plans offered on FFEs. The AMA strongly supports consistent implementation of clear standards for appointment wait times regardless of plan type so that as many beneficiaries as possible are protected. Since in-network physicians are frequently booked or not accepting new patients, we believe such standards are a necessary complement to time and distance standards to ensure true access to timely in-network care. Such standards should be developed in consultation with appropriate medical specialty societies for new and continuing patients and for urgent and non-urgent health care needs. If HHS is concerned about overburdening states, the agency can offer enforcement assistance, but should not miss this critical opportunity to enforce consistent standards across both FFEs and SBEs.

The AMA encourages the use of the following criteria to evaluate the sufficiency of provider networks and further supports development and implementation of additional network adequacy standards for QHPs participating in federal or state-run exchanges:

- Minimum physician-to-enrollee ratios across specialties and subspecialties for providers who are accepting new patients, including mental health and substance use disorder providers;
- Minimum percentages of non-emergency physicians available on nights and weekends; and
- Sufficient physicians to meet the health care needs of historically marginalized people, including (but not limited to) those experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency.

Telehealth

To count toward meeting time and distance standards, the proposed rule states that individual and facility providers listed in Tables 10 and 11 would need to have in-person services available. **The AMA does not support counting providers who only offer telehealth services towards network adequacy requirements and therefore supports this provision.** Although the AMA strongly supports integrating telehealth into the delivery of health care when clinically appropriate, we urge caution when integrating telehealth into network adequacy standards which could potentially lead to fewer in-person physicians in a network and thereby limit access to in-person care. The AMA maintains that telehealth should be a supplement to, and not a replacement for, in-person provider networks so that patients can always access in-person care if they choose, which is important because telehealth is not appropriate for all services or patients. Consistent with newly adopted AMA policy, we also believe that in-network physicians who provide both in-person and telehealth services may count towards network adequacy requirements on a limited and ideally temporary basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a documented shortage of physicians in the needed specialty or subspecialty within the community served by the plan. This should be regularly re-evaluated to ensure patients have access to in-person services to the maximum extent possible.

HHS is also proposing to mandate that state exchanges and SBE-FPs require all issuers seeking QHP certification to submit information to the exchange about whether network providers offer telehealth services. We support the collection of such information since this data, though not intended to be displayed to consumers, has the potential to inform future policy on telehealth and access to care.

Special Enrollment Periods

HHS is proposing to align regulations on special enrollment periods for all exchanges by requiring SBMs to make coverage effective on the first day of the month following plan selection. The AMA supports this change, which will reduce gaps in coverage in states where coverage is only made effective on the first day of the second month when a plan is selected between the 16th and last day of the month. Even brief gaps in coverage lasting days or weeks can be disruptive in terms of interrupting necessary treatments and services, medication adherence, and continuity of care. We believe this proposal to align coverage effective dates will help streamline coverage transitions for consumers moving to an exchange plan from other sources of coverage and urge implementation of this change as soon as possible. Because the proposal will not eliminate coverage gaps entirely for individuals transitioning to exchange plans, we also support the facilitation of automatic coverage transitions that meet certain standards around consent and ability to opt out.

Essential Health Benefits (EHBs)

HHS is proposing several changes that would simplify the process and standards that states use to select new or revised EHB-benchmark plans, beginning on or after January 1, 2027. Under the current rule, states have three alternative options to update their benchmark plans and their EHB scope of benefits must adhere to two parameters: (1) the typicality standard, under which the proposed EHB benchmark plan must provide a scope of benefits equal to, or greater than, that provided under a typical employer plan; and (2) generosity standard, under which the proposed benchmark plan must provide a scope of benefits that does not exceed the generosity of the most generous plans among a set of comparison plans. In response to input from states that the typicality standard is burdensome, and that the generosity standard does not allow sufficient flexibility in updating benefits to reflect employer plans that are more generous, HHS would consolidate the three options for states to update their benchmarks plans and would revise the typicality standard so that states would only need to assess two typical employer plan options, i.e., the most and least generous available, to set a range for the scope of benefits. HHS also proposes to remove the generosity standard. The AMA supports these changes and agrees with HHS that such streamlining could reduce the time and cost to states that are seeking to update their EHB benchmark plan and result in a broader scope of benefits that reflect updated employer plans, which now often cover telehealth services, bariatric surgery, infertility treatment, gender-affirming care, hearing aids, travel-related benefits, and dental care. Finalizing these proposed revisions will help to expand access to critically needed health care, especially to address unmet health needs in historically marginalized communities.

Consumer Protections and Flexibilities

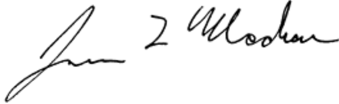
The AMA supports the expansion of existing consumer protections and creation of new flexibilities to protect vulnerable patient populations. Specifically, the AMA supports extending certain consumer protections to state EHB benchmark plans and prescription drug plans by not considering benefits covered in a State's EHB benchmark plan "in addition to EHB." These protections include prohibitions on discrimination, limitations on cost sharing, and restrictions on annual or lifetime dollar limits. Ensuring these important protections are consistent across plans is critical to ensuring they are operating as intended and protecting patients, particularly those who are from historically marginalized communities and/or economically disadvantaged.

Similarly, proposed new, limited exceptions that would allow issuers to offer more than two non-standardized plan options per network type, metal level, and service area if the issuer can demonstrate that these additional non-standardized plans have specific design features that would substantially benefit consumers with chronic and high-cost conditions strike an appropriate balance of maintaining a manageable number of plans while allowing for targeted plans that could improve coverage and access for medically complex populations. For this reason, the AMA also supports this proposal.

The AMA also supports proposed changes to improve and simplify the plan shopping experience for all consumers, including requiring that exchanges operate a centralized eligibility and enrollment platform such that it allows for the submission of a single, streamlined enrollment application for enrollment in a QHP and insurance affordability programs and performs eligibility determinations. We also support ensuring that current minimum federal standards related to the display and marketing of QHP and non-QHP plans and disclaimer language by downstream agents and web brokers also apply to web-brokers in states with SBEs. The AMA believes having a streamlined and informed shopping experience is critical to consumers feeling informed and empowered to select the optimal plan for them, and these important protections should extend to all consumers regardless of state or exchange type.

The AMA commends the Administration for its continuing commitment to extending health insurance coverage to more Americans and making it easier and more affordable to get covered. 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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