

January 27, 2022

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: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

Dear Administrator Brooks-LaSure:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the Notice of Proposed Rulemaking (proposed rule or NPRM) on the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) for 2023. The proposed rule would restore provisions that protect consumers from discrimination in health coverage related to sexual orientation and gender identity, facilitate choice in meaningful health coverage, and ensure adequate provider networks. The AMA commends the Administration for their commitment to extending health insurance coverage to more Americans and making it easier and more affordable to get covered. We also appreciate CMS' focus on addressing health equity in health plan design by prohibiting discrimination and through other equity provisions in the proposed rule, as discussed below.

### **Standardized Options**

CMS is proposing to require issuers to offer at least one standardized plan at every product network type, metal level, and in every service area where the issuer also offers non-standardized plans. Such standardized plan options would include one bronze plan, one bronze plan that meets the requirement to have an actuarial value up to five points above the 60 percent standard, one standard silver plan, one version of each of the three income-based silver cost-sharing reduction (CSR) plan variations, one gold plan, and one platinum plan. The plans would have standard deductibles and annual out-of-pocket maximums, four-tier drug formularies, certain deductible-free services, and a preference for copayments over coinsurance. Preferential or differential display of standardized plans would be resumed on HealthCare.gov, and such display requirements would be extended to web brokers and insurers that use direct enrollment.

The AMA supports this approach. 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 have to 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 have to select from more than 160 different plans. Within a specific metal tier, or even within a particular metal tier and a specific issuer, patients 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. Creating and highlighting standardized options with meaningful differences for consumers would be a step in this direction. Further, the AMA urges CMS to resume the “meaningful difference” standard that was previously codified at 45 CFR 156.298, which will ensure that qualified health plans are “meaningfully different” from other plans offered by the same issuer within a service area and metal tier.

### **Provision of Essential Health Benefits**

CMS is proposing to no longer allow states to permit issuers to substitute benefits between essential health benefit (EHB) categories, recognizing the potential for between-category substitution to be particularly harmful to people living with chronic conditions and disabilities. The AMA strongly supports this amendment to § 156.115. No issuer or its designee should adopt or implement a benefit design that discriminates on the basis of health status, race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present, or predicted disability, degree of medical dependency, quality of life, or other health conditions. The AMA supports the prohibition of EHB substitutions that do not exist in a state’s benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage.

### **Annual Eligibility Redetermination**

CMS is seeking comment on incorporating the net premium, maximum out-of-pocket (MOOP), deductible, and annual out-of-pocket costs (OOPC) of a plan into the exchange re-enrollment hierarchy as well as additional criteria or mechanisms to ensure the hierarchy for reenrollment aligns with plan generosity and consumer needs. The AMA underscores that a plan’s provider network is an important factor in a patient’s choice of health plan, in addition to premium and cost-sharing levels. Recognizing that within a service area, many issuers offer multiple provider networks, the AMA strongly urges that provider network considerations be incorporated into any future changes to the re-enrollment hierarchy. Respecting a patient’s choice of a provider network in the hierarchy will help ensure continuity of care and uphold patient-physician relationships.

### **Network Adequacy**

CMS is proposing to establish stronger network adequacy standards for Qualified Health Plans (QHPs) offered through federally facilitated exchanges (FFE) beginning in plan year (PY) 2023. The AMA strongly supports this effort in order to promote timely access to accessible care from in-network providers and ensure patients receive value for their health insurance premiums. The AMA believes that state regulators should have flexibility to regulate their provider networks, but we also believe there is a critical need for a minimum federal network adequacy standard that includes quantifiable standards, especially in light of inaction in many states to update network adequacy requirements. We urge CMS to use this opportunity to establish a federal minimum standard for QHPs and not limit these requirements to QHPs in FFEs.

The AMA agrees that the time and distance between patient and provider is an important measurement of network adequacy and urges CMS to finalize its proposed requirement to (re)establish this standard. Additionally, the AMA strongly supports the addition of emergency medicine, outpatient clinical behavioral health, and pediatric primary care to the previously developed list of “individual provider specialty types” used for evaluation of time and distance requirements (Table 18). A network would not be adequate if it did not have in-network providers of these specialties accessible to enrollees. However, we suggest that CMS separate outpatient clinical behavioral health into outpatient clinical mental health and outpatient treatment substance use disorder for measurement under Table 18 to ensure access to appropriate providers. Failure to differentiate between these two different types of behavioral health care could result in networks being inadequate to meet the needs of many enrollees. This is critically important in light of the nation’s drug overdose epidemic, as well as the mental health needs of the population that have multiplied during the COVID pandemic.

In terms of facility specialty types, the AMA supports the addition of urgent care to the list in Table 19, as well as the recognition that enrollees should have access to a variety of behavioral health facilities at the residential and inpatient levels of care.

#### Wait times

The AMA also strongly supports the use of wait times as an additional measurement of network adequacy. In fact, the AMA views wait time requirements as a necessary complement to the time and distance standard to ensure true access to timely care. 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. As such, we urge CMS to clarify that wait time standards are applicable to all providers and facilities listed in Tables 18 and 19, as appropriate. Additionally, we again ask that CMS separate behavioral health services into two categories in Table 20—mental health services and substance use disorder services—to ensure appropriate access to specific care and prevent responding to both patient and referring provider complaints. Enforcement of these provisions is essential to ensure access to in-network care for patients.

#### Additional standards

The AMA believes that CMS has an important opportunity to consider and implement additional quantitative standards to measure network adequacy to better evaluate access to timely and appropriate care for enrollees in QHPs. The AMA encourages CMS to consider additional measurement and data to gain a more comprehensive understanding of the adequacy of provider networks, such as:

- Minimum full-time specialist-to-enrollee ratios by specialty, including facility-based health care professionals and minimum full-time primary care physician-to-enrollee ratios;
- Geographic accessibility of health care providers, including primary care physicians, specialists, facility-based health care professionals, hospitals, and urgent care;
- The hours of operation of health care providers in the network;
- Provider’s capacity to accept new patients; and
- The ability of the network to meet the needs of enrollees, which may include low-income persons, children, and adults with serious, chronic, or complex health conditions or physical or mental disabilities or persons with limited English proficiency.

Additionally, the AMA encourages CMS to require reporting of network changes to regulators that may

render the network inadequate for certain services, along with the actions that the plan is taking to correct the inadequacies and ensure access to care for enrollees.

### Telehealth

The AMA supports the collection of information related to whether network providers offer telehealth, as this information has the potential to inform future policy on telehealth and access to care. The AMA also appreciates CMS' clarification that services provided via telehealth are not a replacement for access to services provided in-person in terms of meeting network adequacy requirements. The AMA continues to study the changing landscape as it relates to coverage, payment, and access to telehealth, and data suggests that telehealth has and will continue to play an important role in increasing access to quality care. For example, studies suggest that telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities; however, drivers impacting inequitable access to telehealth need to be addressed, including gaps in broadband infrastructure, lack of affordable internet connectivity, lack of access to devices and other necessary technologies, and gaps in digital literacy among patients. Telehealth has also played an important role during the COVID pandemic in improving access to mental health care, and all indications are that this will continue.

However, telehealth is best viewed in terms of provider networks as one method of delivering care, and not as a service separate or distinct from care provided via other modalities such as in-person. Clinical requirements may dictate fluid movement between modalities, and it is often impossible for a physician to know whether a telehealth visit may necessitate in-person care. Additionally, patient preferences and situations may change from one appointment to the next and patients should always have the opportunity to access care in-person if they choose. Therefore, telehealth should remain a supplement to, not a replacement for, in-person provider networks.

Moreover, insurers should allow all contracted physicians to provide care via telehealth. Prior to the pandemic, many insurers established a separate network for telehealth or select telehealth providers which did not always include contracted physicians who provided in-person services. With the increased demand and changing regulatory environment during the pandemic, more physicians have implemented telehealth in their practices and patients are more likely to seek care via telehealth from their regular physician who also provides care in-person. As telehealth has become integrated into physician practices, the perpetuation of separate telehealth networks is no longer justified. In addition, it is confusing for patients and threatens continuity of care and the patient-physician relationship.

Therefore, the AMA urges CMS to maintain the position that telehealth services should not replace in-person services for network adequacy purposes and to pursue requirements that all contracted physicians in QHPs be permitted to provide services via telehealth to improve access to care.

### Unintended Impact of Proposed Network Adequacy Standards

CMS requests comments on potential unanticipated effects of the proposed network adequacy provisions, specifically on provider-insurer contracting. The AMA does not understand CMS' concern expressed in the draft rule of so-called "all-or-nothing" provisions in contracts. We frequently hear concerns from physicians who are required to accept "all products clauses" in their contracts—provisions that allows payers to place physicians in the networks of any of their products without the ability of the physician to negotiate. Additionally, physicians frequently report unanticipated contract changes that impact their fee schedules and workflow, with the choice of either accepting the changes or losing the contract. These are

false choices for many physicians, as walking away from a contract with a large payer can be the difference between maintaining a practice or financial instability. It is not unusual for payers to have this type of market power, given [competition in the health insurance market](#).

Moreover, we suggest that the implementation of quantitative network adequacy standards should make no difference on contracting incentives, since this is simply a means to measure the network adequacy requirements that are already in place and have been for nearly a decade. As CMS states in the proposed rule, ACA implementing regulations require that plans that use provider networks must “maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay.” Moreover, health plan accreditation standards reflect ACA requirements, as well as existing state requirements where applicable.

As expressed by America’s Health Insurance Plans in 2019 in [testimony](#) before the House Education and Labor Committee Subcommittee on Health, Employment, Labor, and Pensions, measuring network adequacy is a practice in which plans already engage:

*Developing strong provider networks that ensure patients have access to the care they need from providers they choose is not only a top priority for health insurance providers, it’s also the law. Most health insurance providers are required by law to meet either federal or state standards for network adequacy; many state standards are based on the National Association of Insurance Commissioners’ Managed Care Plan Network Adequacy Model Act. Although the standards vary between different states, they reflect the common theme that plans must provide options that minimize the distance a patient would have to travel for care. In other words, the law requires that private health plans have robust provider networks and also requires regular verification of their continued compliance.*

As such, the quantitative measurements proposed by CMS should not impact contracting negotiations if plans are meeting existing requirements, but rather these standards will provide federal regulators with valuable tools to measure and enforce what plans purport to already be doing.

#### Tiered networks

CMS proposes for plans that use tiered networks, that in order to count toward the network adequacy requirements on the plan, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. The AMA has long encouraged regulators to adopt such a requirement, recognizing that providers placed in higher cost-sharing tiers, while technically still part of a network, are not truly accessible to most patients. We applaud CMS for recognizing this access issue and proposing this requirement. We urge CMS to finalize this proposal.

#### Essential Community Providers (ECPs) threshold

The AMA supports CMS’ proposal to increase the ECP threshold from 20 to 35 percent. ECPs include those that care for individuals in low-income and/or medically underserved communities and the current threshold is insufficient to protect patients from discriminatory network designs and network structures that leave out providers that care for these underserved patients. The AMA also strongly supports ensuring ECPs placed on higher cost-sharing tiers in provider networks do not count toward meeting this ECP threshold requirement. We urge CMS to finalize these changes.

Additionally, we ask that CMS clarify that the ECP threshold not be applied to ECPs as a single group, but individually to each type of ECP.

Finally, the AMA supports a requirement that plans offer contracts to at least one ECP in the category of “other ECP providers” by offering a contract to physicians who treat substance use disorder, including those who provide in-office buprenorphine as well as at least one opioid treatment program. This proposal would help ensure that low-income, medically underserved patients have access to this essential health benefit, especially as the nation continues to address the needs of those with an opioid use disorder and other substance use disorders.

### **Medical Loss Ratio (MLR) Reporting**

The MLR standard was designed to provide an improved level of transparency in the health insurance market for all parties and to ensure patients that their premiums are spent on actual medical care rather than administrative costs. If an insurer does not meet the 80/85 threshold, the insurer must provide a rebate to its enrollees. This threshold is what balances the premiums that insurers receive versus the profits that insurers earn, and the AMA believes that is the appropriate balance. The AMA appreciates CMS’ concern that even with low MLRs and high rebates in recent years, MLRs are inflated, and rebates should be higher than they are. As CMS notes in the preamble, current regulations describe the types of activities that qualify as quality improvement activities (QIA), but do not specify the types of expenses that may be included as QIA expenses, or the extent to which such expenses must relate to the activity. CMS further notes that this lack of clarity has caused wide discrepancies in the types of expenses that issuers include in QIA, with some insurers attributing indirect expenses, such as the purchase of artwork and travel and entertainment expenses, to quality improvement expenses to inflate health spending. This results in lower rebates for consumers. For this reason, the AMA supports CMS’ proposal to clarify that only expenses directly related to activities that improve health care quality may be included as quality improvement activity expenses for purposes of MLR reporting and rebate calculation.

CMS proposes to clarify that only those provider incentives and bonuses that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes. CMS notes in the preamble that they have observed that some issuers are reporting incentive or bonus payments to providers that are not based on quality or performance metrics, but rather, involve transferring excess premium revenue to providers to circumvent MLR rebate requirements and avoid paying MLR rebates. By “gaming” the system, these issuers are artificially inflating MLR, thereby often eliminating most, or in some cases even all, of the rebate owed to enrollees, regardless of how low enrollees’ claims costs are relative to premiums those enrollees pay. While we support the intent behind CMS’ proposed clarification of clinical or quality improvement standards that may be included in incurred claims for MLR reporting, we are concerned about the requirements and potential burdens that will be placed on physicians to earn the incentive and bonus money.

### **Requirements for Agents, Brokers, and Web Brokers**

CMS proposes to revise its standards of conduct in the federally facilitated exchanges to address certain activities of concern by agents, brokers, and web-brokers. These include new display requirements for web-broker non-Exchange websites; requirements related to QHP comparative information and standardized disclaimer language; a ban on displaying QHP advertisements or otherwise providing favored or preferred display of QHPs based on compensation agents, brokers, or web-brokers receive

from QHP issuers; and a requirement to prominently display a clear explanation of the rationale for explicit QHP recommendations and the methodology for the default display of QHPs on web-broker non-Exchange websites to better inform and protect consumers using such websites. We support these new requirements, especially since agents, brokers, and web-brokers have not been required to provide accurate and unbiased information to potential enrollees. These provisions would help improve transparency for consumers. We also support CMS' proposal to tighten standards of conduct for agents, brokers, and web-brokers to give further protection to consumers.

### **Prohibiting Discrimination Based on Sexual Orientation and Gender Identity and in Benefit Design**

The proposed rule would reinstate protections repealed by the previous administration that prevented discrimination in health coverage based on sexual orientation and gender identity by marketplaces, insurers, agents, and brokers. The AMA strongly opposed those changes and applauds the Biden Administration for restoring the protections to 45 CFR § 147. These provisions, which would explicitly prohibit marketplaces, insurers, agents, and brokers from discriminating against Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals based on gender identity and sexual orientation, are necessary to address the continuing barriers that such individuals face in accessing health care. It is well established that members of the LGBTQ community face discrimination when seeking health care, resulting in poorer health outcomes than their straight and cisgender peers. We strongly support these proposed changes and urge CMS to finalize them.

The proposed rule also would prohibit discrimination in EHB design in insurer marketing practices, by qualified health plans, and by states and exchanges, and provides a regulatory framework to evaluate plan benefit design and implementation based upon clinical evidence and guidelines. Although the ACA prohibits discrimination, some insurers continue to try to discriminate through benefit design to unlawfully deny needed coverage or discourage individuals with chronic and/or high-cost health needs from enrolling in their plans, using exclusions, cost-sharing, formularies, visit limits, provider networks, prior authorization, and other utilization management tools that are arbitrary and not clinically based or appropriate. The AMA strongly supports this proposal and urges CMS to finalize it.

Under these proposed provisions that aim to provide important protections to 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. Often co-pay assistance is the only way that patients with chronic conditions can afford their medication and copay 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 copay assistance obtained by the patient and the additional cost-sharing then paid by the patient before the patient reaches their out-of-pocket limits and exposes them 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.

### **Z Codes**

The AMA supports the collection of the identified ICD-10-CM Z codes and understands the significance of them in delivering thorough, well-rounded care to the patient. The 2021 E/M Office or other Outpatient encounter revisions specifically include "Diagnosis or treatment significantly limited by social determinants of health" as a moderate risk factor in Medical Decision Making (MDM) for the first time.

This inclusion recognizes the broad influence and impact that these conditions have on the work performed by physicians and other qualified health care professionals in some of the most commonly reported services in the CPT code set. While specifically noted as a factor when these encounters are reported using MDM, their existence can also impact the amount of total time required to provide care to a patient; as such, reporting even when total time is used as the basis for code selection, will provide valuable information not only for quality patient care, but in understanding the time impact on physician/QHP workload.

Identification of social determinants impacting patient care is also important for continuity of care across care settings; and ICD-10-CM Z codes are already in use across both the facility and physician settings. ICD-10-CM coding guidelines for reporting and code assignment in this group have been expanding to reflect the unique challenges in reporting and documenting this information, facilitating more complete capture. For example: FY2019 ICD-10-CM Coding guidelines related to Z55-Z65 codes note that, since the information represents social information rather than medical diagnoses, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider. For FY22, the coding guidelines provide additional expansion on reporting capabilities, including providing examples of individuals on a care team whose documentation may be utilized to report these codes (including social workers, community health workers, case managers, or nurses) if their documentation is included in the official medical record. Additionally, patient self-reported documentation may also be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

Lastly, for FY22, the official guidelines state that codes describing social determinants of health should be assigned when this information is documented. Providing increased education and awareness to providers and their care teams of these uniquely expanded guidelines, particularly with the option for patient self-reported documentation (unique to this subset of ICD-10-CM codes) will aid significantly in broader consistent capture, as the additional avenues 'meet the information' at its most logical capture points(s).

### **Comments on Health Equity, Climate Health, and Qualified Health Plans**

#### National Committee for Quality Assurance (NCQA) Health Equity Accreditation

CMS seeks input on requiring QHP insurers to obtain the National Committee for Quality Assurance (NCQA) Health Equity Accreditation in addition to other accreditation requirements. The AMA cautions against such an approach. There may be additional measures for a QHP to demonstrate its ability to deliver services consistent with health equity principles beyond the two options available from NCQA. The AMA encourages CMS to explore and consider other determinants of health equity in addition to just the NCQA Health Equity Accreditation tool. For whichever metric is used to assess a QHP for health equity, the AMA urges CMS not to create an administratively burdensome requirement. The NCQA Health Equity Accreditation is at least a 12-month process, requires the purchase of the standards and survey tool, and also requires the performance of a gap analysis. QHPs have many other requirements to complete in addition to coordinating the health care for their members, so the process to obtain this accreditation should not create a burden for organizations.



Addressing Social Determinants of Health and Data Collection and Use

The AMA is deeply committed to addressing the social determinants of health (SDOH) that lead to health inequities by improving health outcomes and closing disparity gaps which are rooted in historical and contemporary injustices and discrimination. The AMA believes many individuals can benefit from supports offered by social service agencies and community-based programs. These types of programs often provide needed assistance to individuals who may not otherwise receive it and address a variety of social needs. Access to a patient's protected health information (PHI), including data about their SDOH and social needs, can be beneficial to an individual particularly in the case of homelessness, limited access to health care services, or patients receiving multiple supports across a spectrum of services. The AMA recognizes the important role that collection and sharing of SDOH data can have in improving health outcomes. Because negative SDOH can significantly and adversely impact an individual's health, physicians and QHPs are increasingly collecting data on their patient population by screening for individual social risks and working with their patients to address identified social needs, as well as understanding how these factors impact the community at large. According to a study published in *Journal of the American Medical Association*, approximately 24 percent of hospitals and 16 percent of physician practices reported screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence. When researchers asked about barriers to screening, practices and hospitals primarily reported that the lack of screening was attributed to insufficient financial resources, time, and incentives.

Data sharing and significant gaps in current federal privacy law also present barriers to addressing social needs. This includes data sharing between health systems and physicians, as well as between physicians and community-based organizations that assist individuals and localities with getting access to essential social services. However, individuals may not feel comfortable sharing their SDOH data for any number of reasons, including uncertainty of how the information will be used or shared and should never be required to disclose information about their SDOH, social risks, or social needs. The AMA believes that patients should have notice of, understanding around, and control over how their health care data are used and shared by covered entities with parties outside of their clinical care team, particularly for purposes beyond treatment. As with other protected health data, responses to social risk screening forms and questions should remain confidential unless an individual consents to its release. Relatedly, many community-based organizations do not have electronic health records (EHRs) or other types of digital data systems with privacy/security safeguards to ensure the confidentiality and integrity of the individual's SDOH data. Community-based organizations may not have access controls or really any way of ensuring that information about a patient is not accessible to anyone within the organization who does not need to know it. Additionally, there are no restrictions around how the community-based organization may further use or disclose the information to other third parties, which is a significant risk to patient privacy of which patients may be unaware. This potential unintended consequence is significant, particularly in small communities where word travels fast. Most community-based organizations are under no legal obligation to ensure the privacy and security of patient information. Such assurances are very important for both physicians and patients and will be necessary to truly assist with improved health outcomes. It is inappropriate to require SDOH data disclosure to entities that do not have the resources and infrastructure to protect the information. This does not mean that we should not work towards facilitating such information exchange. Rather, prior to implementing regulatory changes, CMS and other federal agencies should prioritize additional financial, technical, and human resources to community-based organizations to help them manage the confidentiality of SDOH data and related protected health information.

Moreover, as the AMA wrote to the Office for Civil Rights last year in response to proposed regulatory modifications to HIPAA, we have significant concerns about how SDOH data collection requirements will be implemented in light of the Office of the National Coordinator for Health Information Technology's information blocking requirements. These requirements require physicians to provide health information to entities or individuals requesting such access on behalf of the patient. However, patients may not always be aware of what information community-based organizations request on their behalf from their physician. Since the information blocking regulations will compel a physician to disclose such information upon request, a patient may not have the opportunity to ask their physician not to share certain pieces of information—physicians will also be unable to utilize the “precondition not satisfied” exception of the information blocking regulations that would have allowed the physician to check with a patient before release of protected health information. So, for example, a church might request information about an individual's medical appointments with the intent of assisting the patient with transportation to those appointments. But if the church receives information revealing the patient's sexual orientation or HIV-positive status, the patient may experience repercussions within his or her church community. They may think that if their physician is sending information to a community-based organization for “health related” services, that the information will remain confidential—something for which there is currently no guarantee.

A clear gap exists in the availability of simple basic needs such as housing, safe drinking water, access to healthy foods and places to be physically active. As a result, the AMA, in collaboration with other health care and community-based organizations, is working to identify and eliminate the structural and social barriers that contribute to chronic diseases. The AMA continues to work to address SDOH through the promotion of diabetes prevention and lowering overall rates of hypertension, as well as our ongoing work to mitigate various other risk factors that can lead to improved health outcomes.

### **Climate Change and Health Equity**

The AMA is committed to advancing health equity in all areas, including as it relates to climate change and the environment, and engaging with stakeholders to advance practical, safe, efficient, and equitable solutions. The AMA recognizes climate change as a significant factor impacting the health of individuals, particularly those who are marginalized and minoritized.

The AMA is committed to advocating for climate change policies that impact health equity. The AMA has long recognized the significant public health threat imposed by climate-related emergencies and has called for physicians to identify patients at risk for extreme heat-related illness, such as the elderly, children, individuals with physical or mental disabilities, people with alcohol use disorders, the chronically ill, and the socially isolated. In addition, patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. As we continue to learn more about the impact of climate change on health, the AMA will work with stakeholders to develop policies that reduce health inequities.

CMS seeks input on what QHPs can do to address climate change's impact on enrollees, including how QHPs can more effectively determine likely climate impacts on their enrollees and particularly the most vulnerable enrollees; determine potential costs of these impacts; and develop plans to mitigate catastrophic and chronic impacts for these populations (that is, plans for resilience). The AMA supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs and supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs. Accordingly, we think that QHPs should be collecting data to

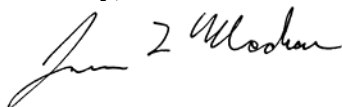
determine climate change's impact on enrollees' health and how to mitigate such impacts to improve and protect the health of the most vulnerable populations confronting increasing natural disasters (e.g., more frequent and intense hurricanes and other storms, fires, excessive heat waves, and flooding).

While the AMA does not have specific data or recommendations on any plans Exchanges may have to assess, reduce, or mitigate its emissions in its operations, we do acknowledge that such plans are needed. On the operations front, information and communications technology (ICT) energy consumption is expected to rise, with data centers expected to surpass the footprint of the aviation sector, and ICT to account for 14 percent of global energy consumption by 2040. Environmentally sustainable data storage should be a top priority.

Similarly, the AMA is interested in the research and education for clinicians about the impacts of climate change on health conditions, especially the preventable onset or worsening those which lead to chronic conditions related to climate change and that may be preventable. For example, asthma and other respiratory conditions are greatly impacted by air quality, so monitoring the relation of emissions to the incidence of chronic respiratory conditions and morbidity would be critical to assessing the health of populations in the vicinity. Furthermore, once a linkage has been established, the root causes of the issue should be addressed. The AMA recognizes this will require much more coordination among federal, state, and local stakeholders, but will be crucial in addressing the long-term health effects of communities.

The AMA appreciates the opportunity to present these comments. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org) or at (202) 789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim L Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD