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Matthew Eyles
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January 27, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

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

Dear Administrator Brooks-LaSure:

On behalf of AHIP, thank you for the opportunity to offer comments in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2023 ("Payment Notice") which was published in the *Federal Register* on January 5, 2022 (CMS-9911-P).[1]

Everyone who buys their own coverage deserves a marketplace that provides them with many affordable, high-quality choices. Today, the Affordable Care Act (ACA) health insurance marketplaces are stable and growing, providing comprehensive and affordable coverage on which a record number of Americans now rely. AHIP and our member health insurance providers share CMS' goals of ensuring that the ACA marketplaces continue to provide affordable choices for comprehensive health care coverage for tens of millions of Americans. We also strongly support the Department's objectives of structuring these marketplaces as another pathway to promote health equity and reduce health disparities in underserved communities.

The recent increase in enrollment through the marketplaces is a significant achievement toward ensuring that every American has the financial peace of mind that health insurance provides. More than 14.5 million Americans have enrolled in coverage through the marketplaces for plan year 2022, a number that is expected to grow once final data is available. The American Rescue Plan Act made certain that more Americans have choices of coverage with a low or $0 premium,

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to making health care better and coverage more affordable and accessible for everyone. We believe that when people get covered and get and stay healthy, we all do better. The best way to do that is to expand on the market-based solutions and public-private partnerships that are proven successes.

and many can receive more generous subsidies to lower their out-of-pocket costs. We applaud the Department's efforts to get more Americans covered, especially through increased Navigator funding and targeted outreach and education for populations were traditionally uninsured or underinsured.

The continued stability and growth of the ACA marketplaces is also due in large part to policies that have promoted a stable regulatory environment, increased competition, and enabled issuers to offer innovative products that consumers want and need. However, we are concerned that some of the policies proposed in this Payment Notice may take large steps backward, undermining this hard-won stability and significantly limiting innovation and competition. Wherever possible, our comments offer workable alternative policy solutions that will achieve similar goals while minimizing disruption for everyone.

Our recommendations address:

- **Nondiscrimination:** Every American deserves access to high-quality, affordable health care, regardless of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. AHIP strongly supports reverting to the pre-2020 definition of nondiscrimination to prohibit discrimination based on sexual orientation and gender identity. We urge HHS to finalize this policy as proposed.

- **Risk Adjustment and Risk Adjustment Data Validation (RADV):** AHIP appreciates the Department's stakeholder engagement on changes to the risk adjustment program. We urge HHS to continue this process for future risk adjustment-related changes, including the future use of 2020 EDGE data. Consistent with our comments on HHS' Risk Adjustment Technical Paper, we support HHS' proposed change to Enrollment Duration Factors (EDFs) for partial year adult enrollees with one-or-more HCCs in the individual market. We also request additional clarity under the proposed RXC mapping policy for drugs with multiple indications. AHIP has significant concerns about the proposed collection, extraction, and analysis of new data elements and encourages HHS to recognize the current challenges and obstacles to data collection and expanded use. AHIP supports the Department's proposed changes to the HHS-RADV calculation methodology, and requests additional clarity around the proposed reporting timeline.

- **Health Equity, Social Determinants of Health, and Climate Health:** AHIP applauds HHS' efforts to gather information and best practices to promote health equity, social determinants of health, and climate health. We have shared our initial work on demographic data collection, health equity measures, continuous learning curriculums, and champion/ally provider designations, and we urge the Department to consider current challenges with data collection and use, accreditation, and barriers to interventions.

- **Essential Health Benefits (EHB) and Benefit Design:** We share HHS' commitment to ensuring benefit designs and coverage decisions reflect evidence-based guidelines and recommendations. Issuers use clinically-based evidence and guidelines from governing bodies such as the U.S. Preventive Services Task Force (USPSTF) to develop plan designs and make coverage decisions. The Department's proposed nondiscrimination framework is overly broad and could create a slippery slope of eliminating benefit limits that are based on clinical evidence, support value-based care, and ensure affordable premiums. The proposed framework would restrict issuers' ability to design benefits or programs that control costs and help consumers manage chronic conditions. We have particular concern that the policy would limit proven strategies to lower Americans' prescription drug costs. If finalized, the Department should address these concerns and provide clear parameters for implementing and enforcing this policy, including an exhaustive list of discriminatory benefit designs based on clinical evidence or research; confirmation that evidence-based coverage limitations are permissible; a call for a cost study demonstrating premium impacts of lifting certain limit; and additional clarity on how this policy interacts with state mandates and state law.

- **Standardized Plans:** Issuers develop plans to meet consumer and market demands, including designs to help people manage chronic conditions or lower costs. The Department's proposal to require issuers in states using Healthcare.gov to offer standardized plans at every service area, metal level, and product type in which they offer non-standardized plans would stifle innovation and ignore health insurance providers' longstanding experience in designing benefits that meet employers' and consumers' needs. Further, aspects of the proposed standard plan designs that vary from common plan offerings, such as common prescription drug formulary designs, would be challenging for issuers to implement, and could be disruptive for consumers. We urge HHS to take an alternative approach of requiring issuers to offer only one silver level standardized option in each service area in which they participate for plan year 2023 and publish enrollment data to assess whether standardized plan options meet consumer needs.

- **Plan Choice:** HHS seeks input on policies that increase the federal government's role to limit the number of plan choices available to consumers. HHS further seeks input on potential changes to how plans are displayed on Healthcare.gov and annual reenrollment processes. We strongly oppose adopting blunt instruments like limiting non-standard plans or active purchasing that would harm competition, disrupt coverage for existing enrollees, and stifle value-based insurance designs (VBID). As an alternative, we support reinstatement of prior meaningful difference standards to simplify the consumer shopping experience and make it easier to compare the differences between coverage options. We also support working together to reexamine the Healthcare.gov shopping experience to make sure robust decision support tools and an intuitive user experience are in place so that people find the best plan for them.

- **Network Adequacy:** Issuers develop provider networks that promote access to quality care, control costs, and foster competition. The proposed federal network adequacy standards could impede issuer's efforts to develop innovative network designs, raise premiums (especially for enrollees in rural areas), and place a significant new burden on issuers and providers, who are already overwhelmed by the ongoing COVID-19 pandemic. We urge HHS to continue deferring to plan management states that conduct network adequacy reviews with quantitative standards, rather than adopting duplicative reviews in those states. If finalized, we recommend network adequacy standards be deferred to plan year 2024 to provide time to address these outstanding issues and allow issuers the time to change to their networks. We further urge appointment wait time standards be deferred until the pandemic-related provider and staffing shortages are relieved.

- **Medical Loss Ratio (MLR) Changes:** Recognizing the importance of strategies to improve health care quality, AHIP asks the Department to clarify that provider incentives and bonuses related to Accountable Care Organizations, shared savings arrangements, and value-based contracts may be submitted as incurred claims and that plans may continue to claim certain expenditures directly related to supporting quality improvement activities under MLR reporting requirements. We also encourage HHS to allow plans to include expenses related to addressing social determinants of health as quality improvement activities.

Given the broad and substantial set of proposals and significant challenges to fully assess the impact under the short comment time frame, we recommend providing an additional comment opportunities before finalization. Further, if the rule is finalized as proposed for plan year 2023, there is a significant cumulative effect for product development and benefit design, network development, and rate setting, all of which would need to be done quickly after finalization of the rule. We are particularly concerned that finalizing many of these policies for the 2023 plan year would result in a significant change from current requirements and plan offerings, placing a significant strain on issuers and providers and be disruptive for consumers.

We provide detailed comments on these and other provisions of the proposed rule. We appreciate the opportunity to provide comments, and we will continue to work with the Department on policies that promote our shared goal of ensuring access to affordable, quality, equitable coverage and care for everyone.

Sincerely,

Matthew Eyles

Matthew Eyles
President & Chief Executive Officer

AHIP Comments on 2023 Proposed Notice of Benefit and Payment Parameters

AHIP's detailed comments on the proposed 2023 Payment Notice are organized by the following topics:

I. Nondiscrimination Protections

II. Standardized Plans and Plan Choice

III. Network Adequacy and Essential Community Providers

IV. HHS Risk Adjustment and RADV (Part 153)

V. Other Exchange Standards (Part 155)

VI. Other Health Issuer Standards (Part 156)

VII. Issuer Use of Premium Revenue: Reporting and Rebate Requirements (Part 158)

VIII. RFI on Health Equity, Climate Health, and Qualified Health Plans

I. Nondiscrimination Protections

A. Nondiscrimination based on sexual orientation and gender identity (§§ 147.104, 155.120(c); § 155.220(j); § 156.125(b); § 156.200(e); and § 156.1230 (b))

HHS proposes to amend the market-wide nondiscrimination standard and proposes parallel amendments to exchange- and issuer-specific standards to explicitly prohibit discrimination in qualified health plan (QHP) issuer marketing practices or benefit designs based on sexual orientation and gender identity.

Recommendation:

- **AHIP supports the amendments to prohibit discrimination based on sexual orientation and gender identity and urges HHS to finalize this proposal.** Every American deserves access to high-quality, affordable health care, regardless of race, color, national origin, sex, gender identity, sexual orientation, age, or disability. AHIP supports federal law protections that prohibit discrimination based on gender identity, sexual orientation, or pregnancy status, and looks forward to continued engagement with the Department on ways to reduce health disparities and improve health equity for this population.

B. Refine essential health benefits (EHB) nondiscrimination policy for health plan designs (§ 156.125)

HHS proposes revisions to ensure that plan design, limitations, and coverage requirements are not discriminatory and based on evidence-based guidelines. The preamble identifies six examples of presumptively discriminatory benefit designs, including based on age, health conditions, sociodemographic factors, and prescription drug tiering. The policy would take effect 60 days after publication in the *Federal Register*.

Recommendations:

- **We share the goal of ensuring evidence-based guidelines and recommendations are incorporated into benefit designs and coverage decisions.** Issuers incorporate clinically-based evidence when designing benefits and setting limitations and exclusions, including recommendations and guidelines from governing bodies such as the U.S. Preventive Services Task Force (USPSTF), and have guidelines in place to protect against discrimination. Issuers have robust medical review processes in place, including exceptions processes to ensure appropriate access to services and treatment. In the preamble, HHS does not address the role of exceptions processes in providing medically necessary care in a non-discriminatory manner. The Department should provide evidence or research that existing medical management tools and exceptions processes fail to protect consumers from discrimination. Further, HHS has not sufficiently demonstrated its statutory authority to restrict benefit design at this granular level. While we agree nondiscrimination protections are appropriate and necessary to prevent clearly discriminatory benefit designs, the proposed policy would restrain issuers' efforts to create evidence-based plan designs and exceptions processes.

- **Confirm that evidence-based coverage limitations are permissible under EHB nondiscrimination examples.** AHIP shares HHS' goals of ensuring that all members have access to appropriate care. AHIP's member plans have robust medical management processes in place to constantly review, update, and revise clinical guidelines for plan coverage based on new and revised studies, evidence, and best practices. Under proposed section 156.125(c), an issuer would be permitted to appropriately utilize reasonable medical management techniques. HHS should confirm this includes applying coverage limitations where clinical evidence can demonstrate their necessity, such as USPSTF guidelines or other robust determinations.

- **HHS should provide clear guidance with an exhaustive list of discriminatory benefit designs.** In the preamble, HHS identifies six "presumptively discriminatory" benefit designs that would violate the proposed nondiscrimination framework if finalized. However, HHS does not provide evidence or research to demonstrate these benefit designs are inherently discriminatory and that existing medical management techniques, including exceptions processes, fail to protect consumers. The framework, as drafted, is likely to impose costs that outweigh its benefits, both because it is overly broad and because it is likely to lead to a

slippery slope of requests to lift a wide array of benefit limits. We recommend HHS take the alternative approach of identifying specific areas of concerns and the expected outcome so issuers and stakeholders have a clear expectation of how this framework would be applied and enforced. If this policy is finalized, HHS should only proceed with the specific examples that are listed in the preamble, with the exception of prescription drug tiering (discussed further below). Without this explicit limit, the framework could be interpreted overly broadly to preclude benefit limits more broadly, which would harm consumers by significantly driving-up costs and impeding certain plan designs, such as wellness programs and programs aimed at improving the health of members with chronic conditions, such as diabetes management.

- **Issuers should retain the ability to have varied prescription drug tiering.** Issuers rely on pharmacy and therapeutic (P&T) committees—including members who are independent of the issuer and pharmacy benefit manager (PBM)—to review all medications included on their formularies, and these decisions are derived from evidence-based clinical literature and medical best practices. Drugs are placed in tiers based on their safety, efficacy, and cost-effectiveness. We believe the criteria applied by P&T committees align with the "neutral principles" described by HHS in the preamble. An issuer's ability to manage its formulary, including tiering, based on clinical input significantly improves patient safety, reduces drug spending, and, in turn, limits patient cost-sharing and premiums. If finalized, the proposed policy would unintentionally impose costs that far exceed any benefits by limiting the ability of issuers to develop cost-effective formulary plan designs and by compelling plans to ignore the standard use of clinical evidence as a factor in determining the appropriate tier for drugs. In addition, the proposal should be replaced with an alternative that allows issuers to retain the ability to have varied prescription drug pricing to avoid the policy's inevitable result of leading manufacturers to impose higher prices, which will drive up premiums.

- **We disagree that expanded use of telehealth services could be considered discriminatory.** In recent years, and particularly in the COVID-19 pandemic, telehealth and virtual care have become critical tools in ensuring access to care and we have concerns that this definition would undermine this growing care delivery tool. We agree that telehealth is not an appropriate substitute for in-person care in all scenarios but the HHS' assertion that promoting or incentivizing telehealth is discriminatory is not consistent with clinical evidence or consumer experience. Expanded access to virtual care, including with no copay, can make it easier for consumers to see a provider when they are not able to do so in-person or when virtual care lowers the barrier to seeking care. Consumers with serious conditions or chronic conditions can especially benefit from telehealth visits, for example to discuss with a provider whether an office visit is needed, for routine check-ins for medication management, to discuss a treatment plan, or whether new imaging or testing is needed. HHS should not define plan designs that incentivize use of virtual services as discriminatory.

- **Final rules should address the Department's understanding of whether this refinement of Federal policy preempts State law and should provide guidance for states and issuers on enforcement.** State EHB benchmark plans were developed to reflect the coverage requirements and decisions in each state. While states remain the enforcers of EHB, the proposed framework may undermine the ability of states to regulate and put forth benefit packages that best meet the needs of their residents. Because many of the "presumptively discriminatory" limits cited by HHS reflect State EHB benchmark requirements that have been adopted and are currently utilized by states State EHB benchmarks may need to be modified if this policy is adopted as proposed. HHS should provide additional compliance resources to allow plans and states to assess both what state mandates may not be allowed under this proposal and how plans and states can work together to ensure consistent benefit coverage where necessary.

- **We recommend HHS conduct and publish the results of a detailed cost study demonstrating premium impacts for consumers prior to finalizing the proposed framework.** Our review of this portion of the proposed rule suggests that it is likely to impose costs that greatly exceed its supposed benefits. We recommend that HHS first gather information necessary to properly measure and balance the anticipated costs before finalizing a portion of a rule that appears to create a significant cost benefit imbalance. Removing benefit limits, for example age-based limits for services such as autism spectrum disorder, hearing aids, and infertility would result in higher costs. We believe HHS has underestimated the costs of removing such benefit limits and believe a detailed analysis of premium impacts would be appropriate prior to finalizing this policy.

- **Extend the implementation effective date to ensure plans have adequate time to come into compliance.** Any necessary changes related to this proposed policy would occur mid-plan year and could require changes to state EHB benchmark plans and QHP issuer updates to pricing, form and rate filings, IT system build and testing, and other administrative and compliance functions. It would not be possible for issuers to implement this policy within 60 days of finalization. Further, rushed implementation is likely to add confusion and costs. If finalized, HHS should align the implementation effective date to begin with the next plan year starting on or after January 1, 2023.

II. Standardized Plans and Plan Choice

A. Standardized Options (§ 156.201)

Beginning in plan year 2023, HHS proposes issuers in Federally-facilitated Exchanges (FFEs) and State-based Exchanges using the Federal Platform (SBE-FP) must offer standardized QHP options at every product network type, metal level, and service area they offer non-standardized

QHP options. HHS is considering differential display for standardized options on Healthcare.gov and web-broker and direct enrollment pathways.

Recommendations:

- **Empower consumers to compare and select the plan that best meets their individual health care needs.** AHIP shares HHS' goal of helping consumers understand their coverage options and select the best plan for themselves and their families. We recognize HHS' concerns that a large number of plan choices can lead consumers to feel overwhelmed when comparing coverage options. However, we are concerned standardized options would have unintended consequences, including stifling innovation that benefits consumers. We oppose the Department's proposal to require QHP issuers to offer standardized plan options at every product network type, metal level, and service area in which they offer non-standardized plan options. This proposal would exacerbate concerns of "choice overload" by flooding the market with new plan options. Instead, HHS should replace this proposal with one that focuses on improving decision-making tools, increasing support for plan selection, and fostering stability and predictability that drives issuer participation and lowers costs for consumers.

- **HHS should narrow the scope for standardized plans by only requiring issuers to offer one silver level standardized plan option per service area in plan year 2023.** HHS' proposal to require standardized QHP options for every product network type, metal level, and service area will increase administrative burden and significantly expand the number of plan options for consumers to consider during the plan selection process, creating additional confusion. We recommend HHS begin by introducing silver level standardized options. HHS should only expand standardized options, if at all, gradually over time after assessing and publicly reporting standard plan enrollment trends to minimize disruptions and ensure additional standardized options are responding to market and consumer demand. If HHS requires issuers to offer more than one silver level standardized option, issuers will need more time to review and develop product offerings and implementation should begin for plan year 2024.

- **HHS should not limit non-standardized plan options or adopt an active purchaser model.** Issuers develop products based on consumer and market demands, including innovative products that help consumers manage their health and costs. There is no average consumer and no one-size-fits-all plan design. Limiting Exchange offerings to standardized options would harm consumers by constraining issuers' efforts to attract consumers through beneficial, innovative plan designs and would be inconsistent with HHS' recent emphasis on value-based insurance design (VBID). Similarly, limiting plan participation through an active purchaser model would harm consumers by depriving them the benefits of choice and competition. While we strongly oppose limiting non-standardized options, we acknowledge HHS' concerns that consumers in some markets a significant number of plan choices that can

be difficult to meaningfully differentiate. We believe restoring meaningful difference standards would be a more appropriate approach to simplifying the plan comparison and selection process for consumers, while maintaining issuers' ability to provide value to consumers through innovative plan designs.

- **Healthcare.gov should not preferentially display standardized options.** Healthcare.gov should not prioritize standard plans in the default plan results page as this could inappropriately steer consumers into plans that may not be the best options for their unique health care needs. The standardized plan design that HHS proposes could make these plans more expensive than nonstandard plans, and differential display would encourage enrollment in higher cost plans. In addition, there are technical and platform limitations that could prevent QHP issuers or web-brokers with direct enrollment pathways from differential display requirements. However, consistent with our recommendations for enhancing the Healthcare.gov plan compare and shopping experience later in our comments, HHS could consider other options to allow consumers to indicate a preference for standardized options. For example, including "standard" in the plan name, including a standardized plan symbol or other indicator on the plan details page or allowing consumers to select a filter to view standardized plans.

- **If finalized, HHS should issue additional guidance on standardized option plan design requirements as soon as possible so issuers can develop products and meet state filing deadlines for plan year 2023.** There are many outstanding questions related to cost-sharing and plan design elements issuers would be required, or permitted, to include if standardized options are finalized. For example, questions related to tiered benefits, cost-sharing for specific provider types or benefit types not considered in the AV calculator, deductibles and cost-sharing for prescription drugs, etc. HHS should address standardized option plan design requirements with sufficient time for issuers to develop new plan options in time to meet state filing deadlines, many of which are in mid- to late-Spring of 2022.

- **We urge HHS to permit issuers to offer a six-tier formulary rather than limiting to four tiers.** The use of tiered formularies is a well-established and effective manner of reducing the direct and indirect costs to consumers of prescription drugs. Issuers should have flexibility to develop formulary drug tiers in the manner that they determine is most effective in promoting prescription drug affordability. A six-tier formulary is common among commercial issuers than four-tier designs and is permitted by Medicare Part D. By contrast, a four-tier formulary can limit issuers' ability to control drug costs and promote affordable drug coverage. In the previous standardized plan design in 2017-18, the four-tier formulary design was challenging for issuers and if finalized again would be challenging and would result in higher costs for consumers. If HHS finalizes a four-tier formulary design, the implementation date should be delayed as issuers will need time to fit formularies to those requirements.

- **HHS should limit the proposed standardized options to Federal Exchanges states.** The proposed standardized options should not be required for State Exchanges. Eight State-based Exchanges (SBEs) and the District of Columbia State Exchanges offer standardized options. State exchanges are in the best position to determine whether to offer standardized plans in their markets and how to tailor those options to incorporate state mandated benefits and other state-specific considerations. SBEs should not be required to adopt the federal standardized option and should maintain autonomy in deciding which policies will best meet the needs of consumers in their states.

B. Annual eligibility redetermination (§ 155.335)

The Department seeks input on whether it should revise the current reenrollment hierarchy, to incorporate net premium, including maximum out-of-pocket (MOOP), deductible, and annual out-of-pocket costs. HHS requests input on criteria that could be used to incorporate "plan generosity" into the reenrollment hierarchy, rather than the current approach which aims to identify the most similar available plan if the enrollee's current QHP will not be available upon renewal.

Recommendation:

- **We share the Department's goal of helping consumers to understand their total annual costs—including premium and cost-sharing—but we have significant concerns that changing the reenrollment hierarchy to move consumers to a different metal level or different QHP could adversely impact consumers.** We share HHS' commitment to expanding education and improving decision-support tools related to out-of-pocket costs and the impact of deductibles, MOOP, copays, and coinsurance on total annual out-of-pocket costs so consumers enroll in coverage that meets their health and financial needs. However, we believe QHP issuers, Exchanges, and enrollment assisters should incorporate out-of-pocket costs in education and tools for initial enrollment. HHS contemplates altering the reenrollment hierarchy to reenroll a bronze QHP enrollee into a silver QHP with a lower net premium and lower out-of-pocket costs, or reenrolling a current silver QHP enrollee into another silver QHP offered by the same issuer in the same product but with lower out-of-pocket costs.

  Updating the reenrollment hierarchy to reenroll a consumer in a different QHP than they initially selected would cause consumer abrasion and confusion. While premium plays a substantial role in QHP selection, other considerations include networks, formularies, cost-sharing arrangements, and health savings account eligibility. The proposed approach would not take into consideration these other factors and it would not be possible for an Exchange to accurately predict the specific reasons an individual enrollee selected a particular plan or what they prioritize with respect to their coverage. Further, it would be impossible to predict an objective definition of value for individual consumers. That is, it is not possible to know which benefit(s) or plan design features are most valued by a particular consumer and any

assumptions embedded into a standard set of rules in the reenrollment hierarchy may not meet the needs of an individual. We strongly urge HHS to not modify the reenrollment hierarchy to reflect annual cost-sharing. Instead, we include recommendations below (subsection C), to improve initial plan selection so consumers make better informed plan selection at initial enrollment.

C. RFI on Choice Architecture (87 FR 689)

AHIP supports HHS' efforts to improve the consumer shopping and plan selection experience and share the goal of helping consumers enroll in the coverage that best meets their health and financial needs. An important component of plan choice is issuer competition. Competition for consumer enrollment among health insurance providers in the Exchanges has worked: leading to lower costs and more options for consumers to choose plans that work best for them. This is evident in the decrease in average benchmark plan premiums in the Federal marketplace by 3 percent from 2021 to 2022, while the average consumer choices increased from 4-5 health plans in 2021 to 5-6 health plans in 2022.

We are concerned that actions to limit consumer choice and reduce the ability of issuers to offer choices or even to participate at all, such as suppressing nonstandard plan designs, limiting nonstandard plan options, or pursuing an active purchaser model, will reduce competition in the Exchange markets and leave consumers could undermine the movement towards lower premiums and increased plan options for consumers. HHS should instead focus on ways to improve consumer shopping and plan selection process to allow consumers to easily compare and select plans that work best for their individual health needs.

HHS should look to direct enrollment (DE) partner websites and other consumer shopping websites for opportunities to improve the Healthcare.gov plan shopping and comparison user experience. For example, the Healthcare.gov filter process could be more intuitive—the ability to expand filter options can be hard to find and many consumer shopping websites have more front and center filter options. HHS could develop additional interactive tutorials and tools including multimedia approaches for consumers who are vision or hearing impaired and on-demand insurance definitions and concepts to improve consumer comprehension. This could include pop-up or roll-over text where an issuer can provide a brief description in simple terms of the plan's key distinguishing features. HHS should explore options to expand capabilities of up-front decision support tools to include more personalized, nuanced expected care utilization and cost information, and increase guided plan selection through access to agents, brokers, and navigators. We urge HHS to engage with issuers and stakeholders to identify tools and features that would be most meaningful for consumers, including seeking feedback throughout the process to identify, test, and launch changes to the healthcare.gov shopping and plan selection user interface.

III. Network Adequacy and Essential Community Providers

A. Network Adequacy (§ 156.230)

Beginning in plan year 2023, HHS proposes to conduct network adequacy reviews as part of the QHP certification process for QHP plans in states that do not perform plan management functions and do not elect to perform their own reviews. These reviews include using time and distance standards and appointment wait times and includes proposed provider specialty and facility lists where these standards would apply. Plans with tiered networks must contract with providers on the tier that results in the lowest patient cost-sharing. Plans must submit information about telehealth services and HHS requests information about how to incorporate telehealth availability in future years. Finally, HHS solicits comments on unintended impacts of network adequacy standards and ways the Department could limit the use of "all-or-nothing" contracting to reduce health care costs.

Recommendations:

- **In Federally-facilitated Exchange (FFE) plan management states that conduct network adequacy reviews with quantitative standards, HHS should deem these standards sufficient and not impose duplicative federal standards.** States have market, regulatory, and geographic expertise that make them best positioned to review provider networks and determine adequacy. This includes an understanding of local provider availability especially in rural areas, hospital and provider consolidation trends, and other market dynamics that impact provider contracting and access to care. Developing provider networks is one of the core tools available to issuers to create innovative products, control costs, and provide options and value to consumers. Issuers contract with preferred providers or health care systems by negotiating favorable rates to ensure consumers have access to quality care at a lower cost, minimize premium increases, and incentivize value-based care. Not having a fulsome understanding of these local trends will lead to requirements that increase premiums without necessarily improving the value of the plan for consumers. Likewise, HHS should continue to defer to SBEs to set network adequacy requirements rather than imposing federal network adequacy standards that would apply to all exchange types.

- **Use of the Medicare Advantage approach to federal network adequacy review does not accommodate the health plan and provider contracting dynamics that are present in many areas of the country, especially areas with provider shortages.** Today, providing significant steerage to a provider through high performance networks is one of the key levers in keeping premiums low for individuals and families purchasing plans. Issuers strive to offer comprehensive health care coverage in the ACA market at an affordable cost. Issuers contract with preferred providers or provider systems and negotiate a favorable rate. HHS must recognize that in the commercial market, requiring issuers to add new providers to networks will result in higher premiums especially in areas with provider consolidation. Thus, State regulators are best positioned to have insight into commercial market dynamics

in their states and what are appropriate network adequacy standards. If FFE plan management states have quantitative network adequacy standards, HHS should defer to the state's expertise and deem the state standards sufficient and not require duplicative federal reviews.

- **HHS should develop an alternative standard that is more appropriate for provider networks in rural areas with limited provider availability.** While the proposed time and distance standards include more generous standards for rural or critical access areas, these rigid standards still fail to account for the unique challenges of rural areas. Requiring time and distance standards will be detrimental in areas where the population size cannot support multiplies of provider specialty types and could result in bare counties in rural areas if issuers are not able to meet provider thresholds. We urge HHS to work with states and issuers to develop an alternative approach for network adequacy in rural areas that better reflects provider availability and costs in rural areas while ensuring affordable plans remain available.

- **Ensure quantitative tools are based on appropriate measures that reflect provider availability and market dynamics.** The proposed quantitative metrics like time and distance standards and appointment wait times provide a limited view of provider networks. Missing from this assessment are market dynamics such as provider and facility availability, contracting practices, and other unique community characteristics or health care needs. Provider and facility availability can vary considerably based on a number of factors and will be exacerbated by staffing shortages and utilization changes related to the ongoing COVID-19 pandemic. These metrics put additional pressure on providers at a time when our health care system is under significant stress. AHIP encourages HHS to establish and maintain a robust, timely, and transparent exceptions process and allow flexibility for plans to submit appropriate justifications for variations from quantitative metrics that will allow them to be treated as compliant with these new standards in light of the justifications.

- **HHS should conduct ongoing analysis of federal network adequacy requirements to ensure the standards are not unnecessarily restrictive appropriate and working in practice.** HHS should continue to review and refine, if necessary, the federal network adequacy standards to ensure that they are not unnecessarily restrictive without providing value to consumers. For example, if HHS finds many issuers must submit justifications, this could indicate the standards are out of sync with provider availability for certain specialty types or in certain geographic regions, especially rural areas, and should be revised to reflect market circumstances.

- **Preserve the ability for issuers to develop innovative plan designs that reduce enrollee costs by not limiting network adequacy assessment to the lowest cost tier.** HHS' proposal to evaluate network adequacy based on plan contracting in the lowest cost-sharing tier would

undermine these efforts and reduce plans' ability to develop affordable plan options that meet enrollee's needs. Networks are an important part of enrollees' plan selection process and play a critical role in promoting quality, controlling costs, preserving consumer choice, and driving private market competition. This includes tiered network plans which direct patients to higher quality, lower cost providers. Tiered networks provide consumers another choice to enroll in coverage that controls costs, while allowing consumers access to providers across tiers. Limiting issuers to lowest tiered providers for network adequacy purposes will impose costs that significantly outweigh the proposal's benefits, by significantly undermining the ability of issuers to offer tiered products. When issuers have tiered networks, HHS should allow issuers to count providers on any tier, not just the lowest cost-sharing tier. HHS should replace this part of the proposal with one that allows providers on all tiers of issuer products to be counted for network adequacy purposes.

- **We offer the following feedback on network adequacy standards for specific provider types:**

  - **Emergency Physicians**—Emergency physicians should not be included in network adequacy standards. Emergency providers are not required to be credentialed on an individual basis and are not typically displayed in provider directories as enrollees are not able to choose which emergency medicine practitioner they see while in the emergency room. This is a facility-based specialty that should not be evaluated at a provider level for network adequacy. Including emergency physicians would be especially difficult in rural areas. Further including emergency physicians is not necessary since the implementation of the No Surprises Act, which protects consumers when they access emergency care in an out-of-network facility.
  - **Urgent Care—**Urgent care should only be included in network adequacy standards if other similar clinics, such as immediate/convenient care, walk-in, express clinics, etc.—all of which offer same-day access and similar services—are also counted toward this provider type.
  - **OB/GYN—**HHS proposes that OB/GYNs would be required to meet the same time and distance standards as primary care providers (PCPs). Because OB/GYNs are not typically chosen as PCPs, this proposal would create an unnecessarily high threshold for OB/GYN provider contracting. As an alternative, we recommend HHS align with the MA standard rather than creating a new, more stringent standard.
  - **Pediatric—**In some rural areas, pediatricians are not always available and many consumers choose to see Family Medicine providers, which can serve their entire family. HHS should allow Family Medicine providers to count toward Pediatric specialty type when reviewing network adequacy, at least in rural areas.
  - **Facility-based Providers—**For certain provider types included on HHS' proposed specialty list, issuers may contract with a facility instead of specific providers and may not have specific information for individual providers to assess and meet quantitative

standards. These include physical, occupational, and speech therapy and certain behavioral health facilities. HHS should not include these provider types in the specialty list designated for network adequacy requirements.

- **Dental—**We recommend dental providers be excluded from appointment wait time standards. HHS proposes in the 2023 Draft Issuer Letter that appointment wait times for standalone dental plans (SADPs) would only require the dental provider specialty within the Specialty Care (Non-Urgent) category. As most dental benefits are provided by general dental providers, this would not provide a helpful measure of dental wait times.

- **Allow plan flexibility to reflect growing use of telehealth in future network adequacy standards.** Telehealth is a growing and rapidly changing area of care delivery, especially during the ongoing COVID-19 pandemic. As the PHE continues, plans, patients, and providers are still evaluating preferred ways to deliver and receive care and understand how telehealth will change utilization patterns during the current waves of COVID-19 and post-pandemic. The NAIC has undertaken a similar workstream, and HHS should consult closely with their developing and evolving telehealth policy recommendations when considering telehealth changes into network adequacy standards. HHS should also consider adopting a similar approach to Medicare Advantage, where plans can opt to receive a credit toward meeting time and distance standards for contracting with certain providers and facilities that provide telehealth services.

- **Federal network adequacy standards should not be implemented until at least plan year 2024 to provide time to address the challenges listed above and avoid increasing burden on issuers and providers who are already overwhelmed by the ongoing COVID-19 pandemic.** If finalized, the proposed federal network adequacy standards will place new operations challenges on both issuers and providers. Under the current timelines for finalization of this rule and state and federal QHP certification deadlines, there is insufficient time for issuers to make provider network changes needed to meet new time and distance standards for plan year 2023. If adopted, we urge HHS to implement new federal network adequacy requirements no earlier than the 2024 plan year to address outstanding questions related to interaction with state network adequacy provisions, identify a more appropriate standard for rural areas, provide issuers sufficient time to make resultant changes to networks, and lower the time and resource pressure on issuers and providers.

- **We recommend HHS defer appointment wait time standards due to ongoing impacts of the pandemic.** Issuers understand the importance of making sure consumers can access health care in a timely fashion. However, the ongoing COVID-19 pandemic means providers, facilities, and health systems face extreme challenges. COVID-19 related staffing shortages, provider and staff burnout, and increased health care demand have led to longer appointment wait times. Issuers have already experienced relatively low provider engagement throughout

the pandemic and anticipate attempting to collect information on appointment wait times and telehealth at this time would result in low provider response rates. These requirements would place additional burden on providers and may discourage network participation in QHPs in the future. We strongly recommend delaying implementation of this requirement until pandemic-related strain on providers is relieved. When HHS proceeds with appointment wait times, we recommend excluding dental providers from the requirement. When implemented, we recommend HHS require measure appointment wait times in business days to align with NCQA standards, rather than in calendar days.

- **Additional time is needed for collection of information on provider telehealth services.** We recommend HHS delay this information until plan year 2024 filings or, at minimum, a separate data collection after the plan year 2023 QHP certification deadline. Since HHS plans to collect this information to inform future requirements around telehealth, it does not need to be submitted with the 2023 plan year data. Issuers do not have complete information on provider telehealth services for all providers and would need to enhance or newly set up provider data collections. To date, low provider engagement due to resource strains during the pandemic have prevented issuers from gathering similar data. With the goal of not placing significant new burden on providers, we urge HHS to provide additional time for issuers to collect and submit telehealth information.

B. Request for comment on unintended consequences of network adequacy standards (87 FR 684)

AHIP appreciates the Department's interest in the harm caused by hospital anticompetitive contracting practices and encourages HHS to consider ways to limit these practices. Recently, Members of Congress have also highlighted concern with these practices and introduced legislation to end this practice. Health plans create networks to provide access to high-quality, affordable care for enrollees. Practices such as "all-or-nothing" contracting and anti-tiering clauses harm consumers and combined with HHS' network adequacy proposed changes, will increase provider leverage in negotiation and drive-up health care costs for consumers.

We share HHS' concerns that certain providers or facilities will use these proposed network adequacy rules to demand increased rates, additional network contracts for other member or system facilities, and inappropriate placement in a particular network tier. We encourage HHS to take any administrative actions it can to reduce or eliminate the use of these contract clauses and consider this impact when finalizing these rules. To the extent that, in spite of such HHS efforts, such provisions continue to be used, we encourage HHS to allow issuers to provide evidence that providers or hospital systems are using these types of contract provisions in network negotiations and provide plans additional flexibility in meeting network adequacy standards in these circumstances.

C. Essential Community Providers (§ 156.235)

The Department proposes to increase the essential community provider (ECP) threshold from 20 percent to 35 percent of available ECPs in each plan's service area, based on the HHS ECP list for the applicable plan year including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the threshold.

Recommendations:

- **We recommend HHS maintain the current ECP threshold of 20 percent of available ECPs in a plan's service area and focus on addressing health equity and access issues by addressing their root cause.** Under the current process, issuers must identify potential ECPs, contract with them, and have the provider complete the write-in process. Increasing the threshold would create additional burdens for issuers and providers, who are already overwhelmed due to the ongoing COVID-19 pandemic as noted earlier. Unexpected closures, terminations, and provider shortages places additional strain on provider contracting. Rather than increasing the ECP threshold, we recommend HHS focus on alternative approaches to address the root causes of health equity and access, including policies that support and increase the ECP workforce. If HHS proceeds with increasing the ECP threshold, we recommend a more moderate increase for plan year 2023, such as to 25 percent, given the COVID-related challenges facing issuers and providers. We recommend any changes to the ECP standard are effective for the 2024 plan year to avoid placing an increased burden on issuers and providers to make changes in tight timeframes.

- **We recommend HHS adopt an alternate threshold for rural areas where there are fewer ECPs with whom QHP issuers can contract.** Issuers with networks in rural areas with provider scarcity already face challenges meeting the ECP thresholds. Many physicians in rural areas have contracts with hospital systems, meaning in some areas issuers may not be able to contract with ECPs due to hospital privileges. We recommend HHS maintain the 20 percent threshold in rural areas where there are fewer providers with whom to contract and ECPs may not be available or very few may be available for contracting.

- **HHS should not add Medicare-certified Rural Emergency Hospitals to the Hospital ECP category.** Rural Emergency Hospitals (REH) will not be added as a new Medicare provider type until January 1, 2023. Stakeholders cannot yet meaningfully comment on whether or how this provider type should be included as an ECP provider type for QHPs. HHS should not include REHs as an ECP provider type for plan year 2023 and should seek comment on whether they should be included for future years after Medicare implementation.

IV. HHS Risk Adjustment Program (Part 153)

A. HHS Risk Adjustment (§ 153.320)

Data for Risk Adjustment Model Recalibration for 2023 Benefit Year and Beyond
HHS proposes to recalibrate the 2023 benefit year risk adjustment models with 2017, 2018, and 2019 enrollee- level External Data Gathering Environment (EDGE) data, coefficient pricing adjustments to Hepatitis C drugs and removal of hydroxychloroquine from Prescription Drug Categories (RXC) and solicits comments on the use of 2020 enrollee-level EDGE data due to the COVID-19 PHE.

Recommendation:

- **Provide additional transparency and stakeholder input into future use of 2020 EDGE data.** 2020 was an unprecedented year in many ways, and care utilization patterns were significantly disrupted. When considering how to incorporate this data into future models, HHS should solicit stakeholder input when the data is available to determine what approach would be best to accurately account for trends in care during the ongoing PHE and adjusting to a new post-pandemic landscape. HHS should specifically examine 2020-related statistics this Spring, and request industry feedback on how best to proceed with 2020 data, including whether to use 2017, 2018, and 2019 data for 2024 model recalibration.

Risk Adjustment Model Updates
As outlined in detail in the October 2021 Risk Adjustment Technical Paper, HHS proposes three changes to the ACA risk adjustment model to improve predictive accuracy: adopting a two-stage weighted model to address underprediction of low-cost enrollees; creating hierarchical condition codes (HCC)-contingent enrollment duration factors (EDFs) for one to six months to improve prediction of partial-year enrollees; and replacing the current severity illness indicators with interacted HCC counts for severe illness and transplants.

Recommendations:

- **Continue stakeholder process for future risk adjustment program changes.** AHIP appreciated HHS' White Paper process to seek stakeholder input prior to rulemaking. The annual Payment Notice provides limited time for issuers to analyze proposed changes and provide robust feedback. We encourage HHS to continue the White Paper process and provide adequate time for stakeholder input when considering future risk adjustment model changes by providing earlier opportunities for stakeholder listening sessions and technical feedback.

- **Finalize proposed changes to EDFs for partial year adult enrollees with one-or-more HCCs.** Consistent with our comments on the technical paper, AHIP supports finalizing this policy as proposed for the individual market but acknowledges this change may negatively

impact issuers with significant fourth quarter enrollment in the small group market since many small group employers renew their coverage outside of the calendar year, leading to potential concerns about claims timing and sales behavior. Issuers have varying opinions on the other proposed risk adjustment model changes, and are interested in sharing those opinions with HHS. We encourage HHS to continue stakeholder engagement and carefully consider issuer feedback when evaluating these changes.

Risk Adjustment RXC Mapping for Recalibration

HHS proposes changes to the approach for identifying the version of the RXC mapping document for annual recalibration of risk adjustment models. Under the proposed approach, beginning with 2023 recalibration, HHS would use the final Q4 RXC mapping document applicable for each benefit year and continue annual and quarterly review processes, with exceptions for 2017. HHS also details an alternative approach to use the latest RXC mapping document available at the time it recalibrates the model and apply it to all three underlying EDGE data years. HHS also discusses certain drugs and circumstances that may require additional analysis and consideration due to market changes that occur between the risk adjustment data year and the applicable benefit year.

Recommendation:

- **Provide additional clarity for drugs with multiple indications.** Mid-year changes to drugs with multiple indications including drug approvals can negatively impact plan assumptions. HHS should provide more clear criteria for drugs with multiple indications. HHS should provide more clear criteria for drugs with multiple indications to address considerations and concerns mentioned in the 2016 Risk Adjustment White Paper.

B. Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, and 153.710)

Proposed Collection and Extraction of New Data Elements and Extraction of Current Data Elements

HHS proposes to require issues to collect and make available five new data elements beginning with the 2023 benefit year: ZIP code; race; ethnicity; Individual Coverage Health Reimbursement Arrangement (ICHRA) indicator, and subsidy indicator (APTC or at the policy-level). HHS also proposes extracting three data elements issuers provide to HHS as part of required data submissions: plan ID, rating area, and subscriber indicator. HHS proposes to exclude plan ID, ZIP code, and rating area from the limited data set and expand the permitted uses of risk adjustment data and reports.

Recommendations:

- **Do not finalize additional data collection, extraction, and analysis for HHS use.** AHIP is concerned the proposed collection and extraction of plan ID, rating area, zip code, and subscriber indicator will raise significant privacy concerns and potentially expose identifiable information about specific issuers and members. Since the beginning of the ACA risk

adjustment program, HHS has set up a distributed data environment to address these privacy and consumer concerns, including transmitting and storing sensitive information, and has decided against collecting enrollee-level data in the past. This proposal would undermine these efforts. These concerns remain regardless of whether HHS excludes these data elements from a public use file. HHS should not finalize this proposal to collect additional data and expand the permitted HHS uses of risk adjustment data and reports and should instead explore alternatives for data analysis.

- **Recognize current challenges and obstacles to data collection.** AHIP appreciates HHS' efforts to improve and increase data collection efforts for risk adjustment purposes. However, for certain categories that HHS is proposing, such as race, ethnicity, and ICHRA indicators, these data elements are not readily available, difficult to collect, or have limited sample size. Issuers do not have information on ICHRA participation, and this data element is not necessary for risk adjustment. HHS should recognize issuers limitations to collecting and reporting this data and reflect those challenges in planned uses and not require issuers to collect ICHRA data.

Encouraging the Use of Z Codes (87 FR 632)
HHS requests comment on the collection and use of Z codes in addressing social determinants of health to support the risk adjustment program.

Response:
We recommend HHS improve awareness of and work to revise ICD-10 Z codes before expanding use to additional programs. ICD-10 Z codes have potential to better document social determinants of health (SDOH), but additional changes are necessary to make them meaningful to address health-related social needs and expand use. Provider use of Z codes is low for several reasons, including lack of provider awareness, and concerns about how the code information is used.

Information sharing barriers also contribute to low utilization of Z codes. Electronic health records (EHRs) do not provide easy pathways for documenting Z codes associated with specific problems or diagnostics. Any documented Z codes must be shared with issuers and other service providers, such as human and social service providers, so data analytics can be used to identify trends and disparities that inform care and services. New codes should also be created to track when patient SDOH assessments were administered but no needs were identified. Finally, other standardized codes such as LOINC and SNOMED can be documented and shared by more entities, such as providers, payers, labs, and researchers, and offer an additional way to document and share SDOH in ways that improve quality and inform care.

Gaps exist in Z codes to properly document significant socioeconomic barriers to health. For example, new Z codes for food insecurity and education were just created in October 2021, and

codes for transportation insecurity, financial security, material hardship, and other issues were proposed in December 2021 and are still awaiting approval. The language used in Z codes can also be judgmental or blame the individual and should be revised to ensure codes are neutral and patients and providers feel comfortable asking and responding to necessary questions. HHS should focus on filling in gaps and facilitating use of Z codes before incorporating them into risk adjustment methodologies.

C. Risk Adjustment Data Validation Requirements when HHS Operates Risk Adjustment (HHS-RADV) (§§ 153.350 and 153.630)

HHS proposes further refinements to the HHS-RADV calculation methodology, including modifying the coefficient estimation groups in error estimation, defining super HCCs separately for adults, children, and infants, and updating the negative failure rate constraint.

Recommendation:

- **Finalized proposed changes to the HHS-RADV calculation methodology.** AHIP supports HHS' three proposed RADV changes to modify the coefficient estimation groups in error estimation, define super HCCs separately for adults, children and infants, and update the negative failure rate constant. HHS should finalize these changes as proposed.

- **Provide additional clarity around reporting timeline.** HHS should provide specific instructions on reporting and timeline requirements and how the current MLR and Risk Adjustment reporting timelines interact. One option HHS could consider is to change the proposed submission deadline to June 30 to avoid refiling after the July 31 MLR data submission deadline.

V. Other Exchange Standards (Part 155)

A. Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs (§ 155.220)

The Department proposes to codify several changes to agent, broker, and web-broker requirements. First, HHS proposes requiring web-brokers to display a minimum set of comparative information so that web-broker websites display the same information comparing QHPs as Healthcare.gov. Second, HHS proposes to prohibit web-broker websites from displaying QHP advertisements, recommendations, or provide preferred display of QHPs based on agent, broker, or web-broker compensation provided by the QHP issuer. Further, web-broker websites would be required to display an explanation of the rationale for QHP recommendations and the methodology for default display of QHPs. Third, agents, brokers, and web-brokers would be required to provide correct information for an enrollee when completing an eligibility application.

Recommendations:

- **HHS should finalize the proposed guardrails related to display of QHPs on web-broker websites.** Consistent with prior AHIP comments, support HHS's proposal requiring all websites that support Exchange plan comparison, eligibility determinations to display the same minimum comparative information on QHP. This ensures consumers have access to complete and accurate information on the QHPs available in their service area so they can review all available options and select the option that best fits their needs. Requiring a minimum set of display information, prohibiting preferential display, recommendations, or QHP advertisements based on broker compensation, and requiring web-brokers to display the rationale for QHP recommendations and methodology for default display of QHPs would support this goal.

- **We support the proposed requirements to ensure agents, brokers, and web-brokers provide accurate enrollee information to the Exchange.** QHP issuers share HHS' commitment to promoting program integrity and limit scenarios where consumers are signed up for coverage, particularly subsidized coverage, without their knowledge or using inaccurate information. We urge HHS to finalize the proposed guardrails, at new § 155.220(j)(2)(ii)(A) through (D), to prohibit agents or brokers from using inaccurate information including email address, phone number, mailing address, and household income when helping a consumer complete an eligibility application and sign up for coverage.

B. Proration of Premiums and APTC (§§ 155.240(e), 155.305(f))(5), and 155.340)

The Department proposes modifications to §§ 155.240(e), 155.305(f))(5), and 155.340 which, together, would require all exchanges, including SBEs, to prorate premiums of individual market policies and APTC, when applicable, when an enrollee is enrolled in a particular policy for a partial month.

Recommendation:

- **We support the requirements that all exchanges, regardless of type, to prorate premiums and APTC, when applicable, for partial month enrollments.** While the FFE currently prorates premium and APTC for partial months of coverage, not all SBEs do so. We strongly support finalizing the requirement to promote consistency across exchanges, which would lower operations burdens for issuers participating across multiple types of exchanges. Further, it would increase the accuracy of APTC, thus reducing potential overpayment of ATPC which can expose taxpayers to a taxpayer liability if APTC exceeds PTC for which they were eligible.

C. Special Enrollment Periods – Special Enrollment Period (SEP) Verification (§ 155.420)

HHS proposes to limit the qualifying events for which SEP pre-enrollment verification applies. If finalized, FFEs and SBE-FPs would only continue to conduct pre-enrollment verification for consumers who attest to a qualifying life event due to loss of minimum essential coverage.

Recommendation:

- **We do not support the proposal to limit SEP pre-enrollment verifications and urge HHS to instead maintain its current approach.** Consistent with prior comments around proposed changes to enrollment and SEPs, we urge HHS to ensure policies strike a balance between maintaining a stable risk pool and lowering barriers to coverage. SEP pre-enrollment verification promotes a stable risk pool and reduces the negative impact of the abuse of SEPs We are concerned that removing SEP pre-enrollment verification, together with recent policy changes including a longer open enrollment period and continuous enrollment for individuals with incomes under 150 percent of the federal poverty level, will have the cumulative impact of destabilizing the individual market risk pool and raise premiums. Instead, HHS should prioritize policies that encourage 12 months of continuous coverage. We believe it is reasonable to verify that individuals enrolling outside of open enrollment have a valid SEP qualifying event and appropriate documentation. To the extent there are differences among consumers providing documentation, HHS should take the alternative approach of evaluating its processes to determine why some consumer groups face barriers and redesign documentation collection processes and remove barriers to make it easier for them to submit documentation. We support further automation of pre-enrollment SEP pre-enrollment verification to streamline this process.

VI. Other Health Insurance Issuer Standards (Part 156)

A. FFE and SBE-FP User Fee Rates for the 2023 Benefit Year (§ 156.50)

For plan year 2023, HHS proposes user fees of 2.75 percent of premiums for issuers in FFE states and 2.25 percent of premiums for SBE-FP states, the same as the user fee rates for plan year 2022.

Recommendations:

- **HHS should finalize the plan year 2023 user fees as proposed.** In plan year 2022, HHS implemented significant outreach, education, and marketing efforts to increase awareness of Marketplace coverage and subsidies throughout the 2021 Marketplace SEP and in response to the American Rescue Plan Act (ARPA) subsidies. These efforts included robust, targeted marketing to traditionally underserved and uninsured populations and successfully resulted in significant gains in enrollment. We appreciate the analysis HHS provided in the preamble related to its anticipated operations costs for plan year 2023. We agree with, and appreciate, HHS' decision that maintaining the current user fee levels would be sufficient and do not need to be increased, while still maintaining robust Healthcare.gov operations and enrollment support activities.

- **AHIP continues to urge the Department to consider an alternative user fee methodology, a per member per month (PMPM) amount rather than percent of premium.** AHIP has previously recommended HHS switch to a PMPM model, as it would be better aligned with the goals of increasing enrollment and promoting affordability as user fee collections do not rise with premium increases. While the preamble included limited transparency into the Department's expected enrollment and operations costs as it relates to user fees, we urge the Department to continue—and expand—its transparency into use of issuer user fees, especially prior to proposing any future changes in the user fee amount or methodology. Additional transparency into HHS' use of funds would better enable stakeholders to provide feedback on the user fee methodology and amount as it relates to the Departments' policy goals for Marketplace enrollment and operations.

D. State Selection of EHB-Benchmark Plan for Plan Years Beginning on or after January 1, 2020 (§ 156.111)

HHS proposes to withdraw the requirement that states annually report any state-required benefits in addition to EHB and any benefits the state has identified as not in addition to EHB and thus not subject to defrayal along with the state's rationale for its determination.

Recommendations:

- **We oppose HHS' proposal to rescind the requirement for states to report state-required benefits because the requirement is an appropriate and important tool to promote transparency and accountability.** On an ongoing basis, AHIP and its members track state benefit mandate legislative proposals and newly adopted state mandated benefits. A small number of states have identified state-required benefits adopted after December 31, 2011 and have transparent processes in place to identify and defray costs. However, issuers continue to have concerns that not all state-required benefits which rise to the threshold for defrayal as described in Section 1311(d)(3)(B) of the ACA are being identified and defrayed by states. We have strongly supported and continue to support the requirement for states to report benefit mandates, identify which are in addition to EHB, and provide the state's rationale for its determination. The state mandated benefit report would have provided needed transparency and a consistent understanding of new benefit mandates that a state enacts to better inform policymaking, increase understanding of the costs of such requirements, and ensure benefits packages continue to be affordable.

- **We disagree that the assertion that reporting requirement poses a significant burden for states.** States should already have determined the status and cost of mandates enacted since 2012, so the reporting requirement should not place a burden on states of conducting new analyses. After the initial reporting cycle, the administrative burden on states is minimal as reporting is only required when states add an additional state-required benefit.

- **HHS should publish clear technical guidance and requirements for a state's analysis of whether state-mandated benefits are in addition to EHB.** If the requirement for annual state reporting is rescinded, HHS should take the alternative, if less effective step, of publishing technical guidance on the standards, including required actuarial analyses, to determine if a benefit exceeds EHB and, if so, the cost of the mandated benefit, to ensure states and issuers have a consistent understanding of whether a state mandated benefit will actually increase health care costs.

E. Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

HHS proposes to change the actuarial value (AV) de minimis ranges beginning in plan year 2023 to narrow the permissible ranges to: +2/-2 for individual and small group plans except expanded bronze; +5/-2 for expanded bronze; +2/0 for individual market silver QHPs as a condition of certification; and +1/0 for cost-sharing variant (CSR) plans.

Recommendations:

- **We support the proposal to narrow the de minimis ranges for individual market bronze, gold, and platinum QHPs.** We agree the shift in enrollment trends for plan years 2018 to 2021 supports the proposed changes to the de minimis ranges for individual market bronze, including expanded bronze, gold, and platinum level plans. With regard to silver level QHPs, we urge HHS to adopt a single silver-level de minimis range to ensure parity on- and off-exchange. Specifically, we recommend HHS adopt a +2/-2 de minimis range for individual market silver QHPs on- and off-exchange. Applying different standards on- and off-Exchange would undermine the precedent of uniform standards across the individual market. While HHS Exchange consumers who are eligible for subsidies would be shielded from higher premiums resulting from the proposed +2/0 de minimis range, off-exchange enrollees would face higher premiums if this range was applied on- and off-exchange. Thus, we believe a +2/-2 would best balance affordability with maintaining parity on- and off-exchange.

- **HHS should not adopt the proposed AV de minimis range changes for the small group market to avoid disruptions for employers and employees.** Small group market employers prefer the flexibility and plan choices made possible by the current AV ranges, as finalized in the 2017 Market Stabilization final rule. The small group market has not seen the same shift in enrollment to bronze plans that HHS describes in the preamble related to the individual market, and we do not believe small group members face the same challenges in accurately evaluating the difference in cost-sharing between small group bronze and silver plans. If the de minimis ranges are narrowed for the small group market, a significant percent of current plans would no longer meet AV metal level standards. Employers would be forced to give up their current plans and face higher premiums, without a corresponding increase in premium tax credits to offset those premium increases as would occur in the individual market. If

finalized for the small group market, this policy would be disruptive to the small group market.

- **In states with fully merged markets, HHS should maintain the current AV de minimis ranges for individual and small group.** Because different rules cannot apply to individual and small group in states with fully merged markets, AV de minimis ranges must align. To avoid adverse impacts for small group described above, we recommend HHS maintain the current AV de minimis ranges in states with merged markets.

- **HHS should confirm any modification made to meet the new AV ranges for plan year 2023 would meet the uniform modification standards under 45 CFR § 147.106(e) and, therefore, would not be considered a product discontinuation.** The guaranteed renewability regulation at § 147.106(e)(3)(iv) provides that modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product in the individual or small group market meets certain requirements, including that, "[w]ithin the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, *or to maintain the same metal tier level* described in sections 1302(d) and (e) of the Affordable Care Act." This request is further supported by CMS guidance that provides "the magnitude of a change in cost-sharing structure does not affect whether the change is considered a uniform modification *if* the change was solely related to changes in cost and utilization of medical care, or *to maintain the same metal tier*."[2] Such a change would also be considered a modification "made uniformly and solely pursuant to applicable Federal or State requirements" which is considered a uniform modification under § 147.106(e)(2) if the change is made within a reasonable time period after the imposition of the Federal or State requirement, and the modification is directly related to the Federal or State requirement. Heath insurance issuers would be making the change to comply with the new Federal requirement, and doing so for plan year 2023, consistent with the proposed effective date of the new requirement. Treating such a change as a uniform modification would limit disruption resulting from product discontinuations. Without confirming changes to maintain AV meet uniform modification, consumers (and employers, if new de minimis ranges are adopted for the small group market) would face significant disruption if issuers are required to discontinue current plans to meet new AV requirements. This would be especially critical in the small group market if HHS does not accept our recommendation and requires new AV de minimis range ranges in the small group market.

[2] CMS FAQs, June 15, 2015, Q4 (emphasis added).

F. Quality Standards: Quality Improvement Strategy (§ 156.1130)

HHS proposes changes to the quality improvement strategy (QIS) requirements. HHS proposes adopting a new guideline beginning with plan year 2023 that would require issuers to address health and health care disparities as a specific topic within their QIS in addition to at least one other topic area described in section 1311(g)(1) of the ACA (improving health outcomes, activities to prevent hospital readmissions, activities to improve patient safety, wellness activities).

Recommendations:

- **Delay implementation of a required QIS addressing health and health care disparities until issuers have more robust data to identify disparities.** We share the Department's commitment to health equity and support the use of data-driven interventions to address social risk factors and promote health equity as evidenced by HHS' estimate that 60 percent of QHP issuers have submitted quality improvement strategies that address healthcare disparities. However, at this time, the data available to issuers to identify healthcare disparities is limited and may vary by issuer. Data on members' race and ethnicity is often incomplete and inaccurate, making it difficult to accurately stratify performance measures to support the identification of disparities. Moreover, issuers in some states must comply with state laws prohibiting the collection of race and ethnicity data. We recommend HHS work with states to remove barriers to data collection while allowing issuers time to build more robust data sets to support the development and evaluation of a QIS.

- **Reconsider the proposal to establish a QIS focused on addressing disparities as separate from a second QIS addressing an additional topic.** In its report, *Future Directions for the National Healthcare Quality and Disparities Reports*, the Institute of Medicine revised its framework for defining quality to emphasize that equity is a cross-cutting dimension of quality, rather than a standalone domain. AHIP supports embedding equity as a foundational aspect of quality rather than considering equity as a siloed aspect of performance. To this end, we encourage HHS to revise its proposal and instead allow issuers to embed a health equity strategy into their selected QIS topics. For example, if an issuer offers providers a financial incentive for improvement on a specific quality measure, the issuer could stratify that measure by a social risk factor to create improvement targets to reduce any identified disparities. We encourage HHS to build on its guidance on the Quality Improvement Strategy: Technical Guidance and User Guide for the 2022 Plan Year that encourages issuers to address disparities by either implementing an activity to reduce disparities or addressing the reduction of disparities as part of an activity within any other topic area.

- **Remove barriers to addressing social determinants of health.** SDOH are significant drivers of disparities in health and health care. Funding and regulatory restrictions are significant obstacles issuers face in scaling and sustaining funding to address SDOH. Social determinants interventions are not considered "medical services" under medical loss ratio

(MLR) calculations and thus are counted as administrative costs. Allowing issuers to treat SDOH interventions as medical services would allow issuers flexibility to address the social needs of enrollees to reduce the upstream causes of healthcare disparities, encourage investment in addressing SDOH, and promote the sustainability of these interventions.

- **Provide additional technical guidance and clarify the qualifying criteria for projects that reduce disparities.** As noted above, issuers may have limited data on enrollees' demographic characteristics or social risk factors. Limited data will make it challenging for issuers to develop a QIS and track progress as required. AHIP requests that if HHS chooses to finalize the proposal to require a QIS focused on addressing disparities, the Department provide detailed criteria to help issuers develop meaningful projects that fulfill the intent of addressing the healthcare needs of underserved populations. We also ask that HHS allow issuers flexibilities in establishing goals and metrics for success to accommodate the more limited data that may exist to support QIS evaluation and the longer timeframe that it will take to successfully address disparities.

- **Align efforts to address disparities across the Department.** AHIP requests that HHS evaluate potential requirements to address disparities for other populations and work to create alignment along these requirements in support of a population health approach to addressing disparities.

VII. Issuer Use of Premium Revenue: Reporting and Rebate Requirements (Part 158)

A. Reimbursement for clinical services provided to enrollees (§ 158.140)

HHS proposes clarifications that only provider incentives and bonuses that are tied to clearly defined, measurable, and well-documented clinical or quality improvement standards can be included in incurred claims for medical loss ratio (MLR) reporting and rebate calculation purposes.

Recommendation:

- **Allow plans to include provider incentives and bonuses related to Accountable Care Organizations (ACOs), shared savings arrangements, and value-based contracting as incurred claims under MLR reporting.** Provider incentives and bonuses are a critical component of ACOs, shared savings arrangements, value-based contracting, and other innovative contracting approaches that encourage providers to provide efficient care delivery and reward them for successful outcomes while still lowering overall costs. These cost-containment strategies have been applauded and encouraged by HHS in the past across different markets and government programs. The Department should clarify that ACOs, shared savings arrangements, and value-based contracting are not subject to this requirement

and these types of financial performance-based incentives and may be included in incurred claims under MLR reporting.

B. Activities that improve health care quality (§ 158.150)

HHS proposes amendments to the definition of quality improvement activities to specify that only expenses directly related to activities that improve health care quality may be included in MLR reporting for quality improvement activities (QIA).

Recommendations:

- **Allow plans to continue to claim certain expenditures as quality improvement activities under MLR reporting.** Certain categories that HHS lists as indirect expenses, such as staff salaries, benefits, equipment such as phones and computers, and information technology systems, are critical infrastructure and support components that contribute to plans' ability to successfully create, implement, document, and improve current plan initiatives. Similarly, HHS lists "vendor profits" as an indirect expense for QIA activities, even though plans that engage QIA vendors incur these costs as a direct QIA expense the same way as vendor profits for vendors that provide clinical or administrative services. Disallowing a portion of the costs of these vendors' services will discourage plans from engaging vendors with the expertise and resources to properly deliver QI programs and underestimate QIA activities compared to clinical and non-claims costs, resulting in an inaccurate MLR calculation. In addition, existing language under § 158.150 specifically references health information technology.

  Reducing the ability for plans to include these expenses will limit plan investment in quality improvement activities because plans will not obtain sufficient credit for beneficial quality programs and implementation activities. AHIP agrees with the Department that certain costs included in the preamble, such as lobbying, catering, parties, entertainment, and salaries of executives that do not directly oversee quality improvement activities, should not be included in MLR reporting. However, HHS should allow a broader set of support expenses to be claimed as QIA under MLR reporting if plans can demonstrate that these expenses are related to support and execution of quality improvement strategies. HHS should also provide a specific list of examples HHS considers not permitted as direct expenses and clarify that any changes to quality improvement expenses tracking be made prospectively to align with the calendar year for reporting purposes since 2022 programs and contracts are already underway (i.e., changes would be effective for experience year 2023 and would be filed in 2024).

- **Encourage plan investment to address SDOH by including expenses as quality improvement activities.** Funding and regulatory restrictions are significant obstacles plans face in scaling and sustaining funding to address SDOH. SDOH interventions are also not considered "medical services" under MLR calculations and are counted as administrative costs. HHS should broaden the definition of quality improvement activities to include

expenditures for interventions that offset social barriers to care to allow plans to invest more broadly in SDOH initiatives.

VIII. RFI on Health Equity, Climate Health, and Qualified Health Plans (87 FR 693)

A. Health Equity

HHS is considering ways to incorporate health equity standards to enhance criteria for QHP certification and leverage existing QHP requirements. HHS seeks comment on advancing health equity through QHP certification standards, advancing HHS' understanding of the existing landscape of issuer health equity data collection, understanding what ability QHP issuers have to tailor provider networks based on health needs of enrollees in specific geographic areas, identifying ways HHS could measure QHP issuers' progress toward advancing health equity, and developing strategies to overcome challenges.

Response:
AHIP applauds HHS' efforts to gather information and best practices to promote health equity. AHIP and its members agree with the importance of promoting health equity, recognize the relationship between health equity and racial equity, and are actively taking concrete steps to reduce these disparities. We offer the following items for consideration as HHS continues to develop strategies to improve health equity.

Industry Efforts and Challenges with Demographic Data
AHIP has engaged our member health insurers and other stakeholders in an evidence-based and stakeholder driven process to fill in resource gaps by: (1) developing demographic data standards on race, ethnicity, language preference, sexual orientation, gender, disability status, veteran status, and spirituality to better monitor and reduce disparities and inform culturally-appropriate care; (2) developing a set of health equity measures for value based care in the domains of organizational structure/culture of equity, data necessary for equity, partnerships necessary for equity, appropriateness and accessibility of services, member experience, accountability, and quality measures that should be stratified by demographic factors; (3) developing components of a continuous learning curriculum on bias and anti-racism; (4) identifying a list of recommended vendors to develop and deliver bias and anti-racism training; (5) developing a "Champion/Ally" designation for providers who have expertise and are committed to respectfully serving different communities to help consumers find someone they feel comfortable seeing for care. We would be happy to share any of our work and findings with the Department to inform its thinking in these areas.

Demographic data is crucial to identify and reduce disparities as well as monitoring whether provider networks represent the communities served. Data is critical to health equity work, but current demographic data standards, such as OMB, 2020 Census, or others, have flaws that lead

to large rates of "unknown" or "other" categories, which makes the data less actionable. HHS has acknowledged these challenges, reporting 59 percent respond "unknown" when enrolling through the Exchange (and passed to issuers on the 834). HHS should work with federal agencies and engage stakeholders to develop strategies to improve demographic data standards that better monitor and reduce disparities and inform appropriate care. In the interim, HHS could consider the use of Social Vulnerability Index (SVI) scores as part of health equity strategies. Other challenges for HHS to consider include standards for data collection, storage, and sharing which are important to the success of cost evaluation, strategies, and other interventions to mitigate consumer challenges.

When discussing data collection issues, it is important to ensure that data on sensitive issues such as race, ethnicity, sexual orientation, gender identity, and socioeconomic needs is collected in a trusted relationship, requested with a clear purpose and mission in mind, and that appropriate data analysis and review is conducted to ensure proper utilization of the data. Building consumer trust and understanding of the purpose and use of data collection is essential to the success of data collection and application efforts.

Challenges Related to QHP Certification

We believe health equity measures could be used as a way to incentivize a focus on health equity without penalties on QHPs. AHIP has developed a set of health equity measures for value-based care through an evidence-based and stakeholder-driven process with health plans and other stakeholders that we can share for HHS' consideration in its efforts to help incentivize QHPs to focus on health equity. As discussed previously, there are standards gaps that provide data-related challenges, and plans face critical resource, measurement, evidence-based interventions and other information gaps in this area that could lead to unintended consequences. Health equity measures should not be used for public reporting on quality or for payment purposes.

As industry-wide efforts continue around data, standards, and measure development, HHS and issuers should continue to work together to identify unique considerations for QHPs and the consumers they serve. However, it would be premature to require health equity as a criterion for QHP certification or plan accreditation until measures have been appropriately researched, validated, and vetted by diverse groups of stakeholders and communities. AHIP has concerns over requiring QHPs to obtain NCQA's Health Equity Accreditation since it incorporates new elements this year from the previous NCQA Multicultural Health Care Distinction Program that have not yet been tested and lack validation yet that they actually improve health equity. Additionally, we have concerns about requiring a particular distinction program, as such requirements can lead to "lock-in" harms and are especially inappropriate when, as is the case where, there is no evidence that one program is more effective than others. We also have concerns that mandating health equity accreditation will disadvantage smaller, less resourced organizations who may not have the resources or capacity to achieve the accreditation. HHS should continue to work with a broader set of stakeholders to understand which levers can have

the biggest impact on health equity for QHPs, especially issues that are inherently tied to provider workforce outside of issuers' control. Finally, HHS should take rural geographies into consideration where provider recruitment and retention presents unique obstacles for diversity, race, and ethnicity standards.

B. Social Determinants of Health

HHS is considering ways to incentivize QHP issuers to collect data on social determinants of health (SDOH) and response to SDOH needs identified; whether QHP issuers should be required to collect SDOH data; which data elements should be considered; what challenges and barriers exist to collect this data; and what challenges and barriers exist for QHP issuers to address SDOH.

Response:

We agree it is important to understand the impact that structural and socioeconomic factors have on health outcomes and health care disparities. In particular, AHIP agrees that getting better data on patients' social determinants of health is essential to improving both care and performance measurement. Better data will help to identify disparities, confirm patients' needs are being met, and ensure value-based payment models and alternative payment models are fair to providers serving vulnerable populations.

Challenges with SDOH Data Collection and Use

There are still many challenges with collecting and acting on SDOH data: 1) Standards for uniform SDOH data collection and interoperable data sharing are under development; 2) infrastructure to collect, store, and share SDOH data is being built; 3) lack of funding to focus on SDOH; and 4) readiness and capacity of health care, social services, and community-based organizations to collect and share data and mitigate socioeconomic barriers to health is limited. Federal agencies (including HHS) have acknowledged the challenges of collecting self-reported data on SDOH and the limitations of data shared from other federal agencies. Health insurance providers have encountered similar barriers to self-reported data collection. For example, as discussed in the section on risk adjustment, ICD-10 Z codes have potential to better document SDOH, but additional changes are necessary to make them meaningful to address health-related social needs and expand use.

Barriers to SDOH-related Interventions

QHPs face regulatory challenges that limit their ability to address SDOH, such as the $600 threshold limit for medical and health care payments required by the IRS and individual market wellness rules. The $600 IRS reporting requirement limits QHP interventions and wellness program rewards to address SDOH needs. In addition, individual market wellness rules require QHPs to provide programs equally to all enrollees, limiting the ability to provide services to those most in need.

As HHS considers options to address SDOH and advance equity in QHPs, we recommend continued consideration of the challenges related to sociodemographic data collection and QHP's limitations to respond to identified SDOH needs. It will also be important to address the funding, infrastructure, capacity, and resource limitations to ensure organizations have the necessary guidance, resources, and support to improve efforts on SDOH.

C. Climate Health

We recognize there the link between our physical and emotional wellbeing and the health of the environment. Environmental hazards such as air and water pollution can lead to great health risks, like asthma. Moreover, vulnerable communities are put most at risk. Health insurance providers are committed to reducing health disparities, through innovate ways of addressing socioeconomic needs. Across the country, health plans are partnering with local communities to innovate and create new service delivery models to deliver critical resources to vulnerable communities, such as safe and affordable housing, healthy food, and safe drinking water. Addressing and mitigating the impacts of climate change are necessary to improving health outcomes and promoting health equity. One way issuers are addressing the impacts of climate health is through pledges to reduce greenhouse gas emissions or become carbon neutral. Issuers are committed to addressing the likely impacts of climate change and working on appropriate efforts to address and mitigate the harmful effects of climate change on their enrollees.