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January 30, 2023

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 2024—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 2024 ("Payment Notice") which was published in the *Federal Register* on December 21, 2022 (CMS-9899-P).[1]

Tens of millions of Americans now enjoy the improved health and financial stability of health insurance they choose through the ACA Marketplaces. The successful public-private partnership between HHS, Congress, and health insurance providers has led to a very stable market and record-breaking enrollment year-after-year. For 2023, more than 16.3 million Americans selected a Marketplace plan – including a 21% increase of Americans who purchased from the Marketplace for the first time. We applaud the Administration's efforts to achieve these enrollment gains. The continuation of the enhanced advance premium tax credits (APTC) and other expanded subsidies, robust plan choices, and increased education and outreach have led to this historic moment. We look forward to a strong continued public-private partnership to promote affordability, access, choice, and equity, along with strong patient protections.

Marketplace consumers had a choice of between 6 and 7 Qualified Health Plan (QHP) issuers on average for 2023, providing robust competition that offered hardworking

[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.

American families more choices, better quality, and lower costs. We look forward to promoting policies that provide Americans with even more high-quality, affordable coverage choices.

We appreciate HHS' proposals that promote access and mitigate coverage gaps, such as the proposed changes to Special Enrollment Periods (SEP). We are also encouraged by HHS' request for information about including gender dysphoria in the risk adjustment model and look forward to additional dialogue about ways to reduce barriers to care and enrollment for LGBTQ+ individuals.

However, we are concerned that some proposed policies may drastically disrupt the Marketplaces at a time of great change and uncertainty. States will soon be redetermining whether more than a quarter of the U.S. population is still eligible for Medicaid coverage. Of the more than 90 million Medicaid enrollees who are to be redetermined, approximately 10 million will be eligible for other coverage, including Marketplace coverage. As such, the Marketplaces need to be prepared for a massive influx of enrollees over the coming months. Major policy changes, such as the proposals to limit non-standardized plans, amend the reenrollment hierarchy, and further changes to standardized plans could cause severe disruption for both consumers and health insurance providers. As such, we urge caution against implementing significant policy changes that could overburden the health care system and negatively impact affordability, competition, and consumer choice.

Our comments prioritize recommendations that would achieve similar goals while minimizing disruption for Americans. Those recommendations address:

- **Non-Standardized Plan Option Limits:** AHIP shares HHS' goal of ensuring Americans can easily find affordable, high-quality coverage that best meets their individual and family preferences. We understand the Department's concern that people in some markets have a considerable number of plan choices that can feel overwhelming. However, Americans strongly and consistently want choices for their coverage and care, and we strongly oppose HHS' proposal to limit the number of non-standardized plan options to two non-standardized plan options per product network type and metal level.

  Health insurance providers offer a variety of plan designs and benefits to address consumers' varying and unique health needs. Limiting these options would eliminate choice for enrollees that have varying preferences, including value access to high-value networks, broad access to providers, specific plans that contract with particular health systems or provider groups, cost-sharing and premium level preferences, health savings account (HSA) eligibility, ability to add supplemental benefits or other plan offerings, and much more. Furthermore, limiting plan offerings during the unwinding of the

COVID-19 Public Health Emergency and forthcoming Medicaid redeterminations would drastically disrupt the Marketplace.

Instead, we recommend HHS adopt the alternative proposal to implement a meaningful difference standard to make it simpler and easier to compare coverage. We further recommend HHS refine the proposed standard to reduce the deductible differential to $500 and incorporate stakeholder feedback and other factors that consumers value. If HHS proceeds with any changes to limit non-standardized plan options or reinstate meaningful difference standards, we recommend that HHS compare plans at the network ID level, not by network type.

- **Network Adequacy:** Health insurance providers worked in partnership with CMS to implement new network adequacy standards over the past year. To improve the network adequacy review process for plan years 2024 and beyond, we recommend HHS establish clear timelines for the network adequacy review process, including a deadline to notify issuers whether their plan has been approved under the process, and improve the exceptions process to allow additional flexibility in exceptional circumstances.

  We further recommend HHS allow an additional year for issuers and regulators to refine the new network adequacy review process during plan year 2024 QHP certification prior to implementing appointment wait time standards. Delaying appointment wait time standards would allow HHS adequate time to conduct issuer testing and establish a reasonable framework for assessing appointment availability. It would also provide issuers time to prepare self-compliance review processes and operationalize data collection.

  In addition, we recommend CMS adopt a voluntary telehealth credit and that CMS work with the National Association of Insurance Commissioners (NAIC) and other stakeholders to share ideas and gain feedback. AHIP also supports HHS' proposal to implement a limited exception for standalone dental plan (SADP) issuers where it would be "prohibitively difficult" to establish a network of dental providers.

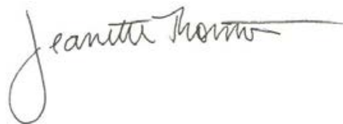
- **Standardized Plan Options:** AHIP appreciates that HHS chose to make limited modifications to the design of standardized plans for the 2024 plan year, further promoting stability in the Marketplace. However, AHIP is concerned the proposed change to classify prescription drug tiers for standardized plans could have severe consequences. These changes limit scenarios that enable issuers to place high-priced brand drugs onto a lower-cost tier, eliminating potential cost-savings and raising prices for consumers. We urge HHS to continue deferring to issuers to establish prescription drug tiers that effectively balance cost, access, and quality for enrollees.

- **Essential Community Providers (ECP):** HHS proposes to require QHPs to contract with at least 35% of both available Federally Qualified Health Centers (FQHC) and Family Planning Providers and to add Rural Emergency Hospitals (REH) as a provider category under Other ECP Providers. AHIP believes patients should have access to a robust network of providers to support their changing health care needs, including ECPs. However, we caution against implementing a threshold for specific ECP categories. Strict ECP thresholds fail to account for provider and population distribution and other factors and could make it more difficult for issuers to meet required ECP provider contracting requirements. Furthermore, we recommend HHS delay adding REH as a separate category under Other ECP Providers until plan year 2025 as states, hospitals, providers, and other stakeholders are still in the process of implementing new REH standards based on recent guidance.

- **Annual Eligibility Redetermination:** AHIP shares HHS' goal of ensuring people have the necessary tools to choose the plan that best fits their needs. However, we oppose HHS' proposal to modify the reenrollment hierarchy to automatically reenroll people into a plan they did not actively select in situations when their current QHP is available, as well as when their current QHP is no longer available. Americans actively choose their health plan for several reasons, including but not limited to net premium, provider network, and out-of-pocket costs. This proposal assumes consumers always value income-based cost-sharing reductions (CSR) and net premium above all other factors – and while this may be true for some, it is incorrect to assume this applies to everyone. Issuers are also concerned about how this policy will affect Guaranteed Renewability of Coverage Requirements, specifically those regarding issuer renewal notices. As an alternative, we encourage HHS to improve consumer decision support tools and education around silver plans.

We provide detailed comments on these and other provisions of the proposed rule in the Attachment. We appreciate the opportunity to provide comments and look forward to continued partnership with HHS to ensure affordable, quality, equitable coverage and care is accessible to everyone.

Sincerely,



Jeanette Thornton
Executive Vice President, Policy and Strategy

Attachment
AHIP Comments on 2024 Proposed Notice of Benefit and Payment Parameters

AHIP's detailed comments on the proposed 2024 Payment Notice are organized by the following topics:

I. Non-Standardized Plan Option Limits
II. Standardized Plan Options
III. Plans that Do Not Use a Provider Network: Network Adequacy and Essential Community Providers (ECP)
IV. Essential Community Providers
V. Annual Eligibility Redetermination
VI. Risk Adjustment and Risk Adjustment Data Validation (RADV) (Part 153)
VII. Exchange Standards (Part 155)
VIII. Issuer Standards (Part 156)

I. Non-Standardized Plan Option Limits (§ 156.202)

AHIP strongly encourages HHS not to limit non-standardized plan options for the 2024 plan year. We strongly oppose adopting blunt instruments like limiting non-standardized plans that would harm competition, disrupt coverage for existing enrollees, and stifle value-based insurance designs. However, if HHS proceeds with a proposal to limit the number of non-standardized plans on the Exchange, AHIP has several recommendations to ensure consumers continue to have robust coverage options that meet their individual health care needs.

AHIP acknowledges HHS' concern about the impact of choice overload for consumers in certain markets and their ability to meaningfully differentiate between a considerable number of plan choices. However, consumers on the Exchanges have many different needs and preferences for health coverage. For example, some consumers are price-conscious and prefer plans with lower premiums and high-value networks, while others value access to a variety of specialists and prefer plans with broad networks. Some consumers may prefer specific plans that contract with a particular health system or group of providers. Under this proposal, issuers would not be able to offer the range of network options available today and would be forced to make strategic decisions about which networks and plan offerings are available, stifling issuers' ability to innovate and expand plan designs. Some issuers also offer different benefit tiers in each of their plan offerings or include plan options that incorporate supplemental benefits like vision or dental coverage into their base plan. The proposed non-standardized plan limitation would not allow for the current amount of benefit tiers or supplemental plan options available today and stifle innovation for future offerings and expansions.

AHIP has particular concern about the timing and administrative challenges of the proposed changes. AHIP has partnered closely with its members, HHS, states, and other stakeholders to prepare for the forthcoming wave of Medicaid redeterminations that are to begin as early as February 1 and will continue through March 2024 (depending on when a particular state begins and concludes its process). At the same time, HHS is proposing changes that, according to estimates included in the preamble, could eliminate over one hundred thousand plan options and require up to one-quarter of FFE enrollees to switch to a new plan. Enrollees who have recently enrolled in Exchange coverage from Medicaid may have to switch again at the start of 2024. This significant disruption of the Marketplace at a critical time for coverage transitions from Medicaid to the Exchange would pose substantial operational challenges for plans, including notice and reenrollment requirements, and result in widespread consumer confusion and disruption of care.

Additionally, the product development process is already in progress and depending on the timing of the Payment Notice Final Rule, state filing processes would likely already be underway. Issuers have already made strategic decisions about plan offerings and participation and finalizing these changes for the 2024 plan year would result in significant operational challenges and rework, jeopardizing the ability for issuers to continue offering coverage in existing service areas.

Limiting non-standardized plan options is not the best method to improve the plan selection process for consumers. We encourage HHS to work with issuers to improve consumer decision support tools available on healthcare.gov to assist consumers with plan selection and the overall plan shopping experience and find the best plan that fits their needs. Optimized consumer tools to filter plan options, describe plan features, assess consumer health care utilization, and improve the plan selection process would benefit consumers more than limiting non-standardized plan options. We offer additional recommendations on improving consumer decision support tools in Section V of our comments below.

As an alternative to limiting the number of plans, AHIP recommends that HHS restore a meaningful difference standard instead of a numerical limitation. Restoring a meaningful difference standard would ensure that plans on the Exchange within each metal tier are truly different from one another and provide different options for consumers without sacrificing the different features and options that are available today. A meaningful difference standard would simplify the consumer shopping experience and allow for easier comparison between coverage options. We recommend that HHS lower the threshold included in a meaningful difference standard from $1,000 to $500. A threshold of $1,000 is extremely high and does not account for consumer preferences, particularly for price-sensitive consumers that may prefer a higher monthly premium with a lower deductible limit, or vice versa. A $500 standard would incorporate additional flexibility and options for consumers with varied budgets and preferences. A new meaningful difference standard should also build upon the previously codified standards

and incorporate updated factors such as provider networks, plan design, cost-sharing, HAS eligibility, and other features, not just a deductible variation. Consumers shop for plans with a number of different priorities in mind, and only differentiating plans based on deductibles does not adequately account for these important plan differences.

Second, if HHS proceeds with any changes to limit non-standardized plan options or reinstate meaningful difference standards, we recommend that HHS compare plans at the network ID level, not by network type. The product network type category is a broad definition based on legal structure and covered benefits and does not capture key differences in provider networks, such as specific in-network providers and health systems, network breadth, or other important distinctions that are meaningful for consumers. Modifying the limitation to compare plans at the network ID level would ensure that different consumers looking for specific types of networks still have high-value, broad, or specific health system-affiliated options. If HHS does not make this change, we are concerned that consumers will no longer have access to these types of networks, which are extremely popular with some consumers for their unique benefits. In addition, we recommend that HHS compare product type to allow for additional variation of benefit tiers, supplemental benefits, telehealth or other benefit options into their base plan.

We further recommend that HHS exempt certain plan designs required by states from the standard, if finalized. Some states require issuers to offer plans with specific benefit and cost sharing structures. When a plan is offered in order to meet a state requirement like this, it should not count towards the HHS limit on non-standardized plans.

Recommendations:

- **Do not limit non-standardized plan options for the 2024 plan year due to the market uncertainty and disruption caused by the Medicaid redetermination process.**
- **Improve healthcare.gov consumer decision tools to educate and empower consumers during the plan selection process.**
- **Restore a meaningful difference standard that reduces the deductible differential to $500 and incorporates stakeholder feedback and other factors that consumers value.**
- **If CMS pursues any limitations on non-standardized plan options, including a meaningful difference standard, differentiate plan offerings at the network ID level, not network type, and exempt plan designs that are already required by states.**

II. Standardized Plan Options (§ 156.201)

AHIP appreciates HHS' proposal to make limited modifications to standardized plans for the 2024 plan year and encourages HHS to maintain consistency in standardized plan design to limit enrollee disruption and confusion. AHIP has significant concerns about HHS' proposal to limit issuers' ability to classify prescription drug tiers for standardized plans. Issuers

design prescription drug tiers based on clinical standards to maximize efficacy, quality, and affordability for enrollees, and they are often standardized at a product or issuer level. Mandatory formulary requirements do not adequately reflect patient-centered value definitions, such as adherence, pill burden, administration, absenteeism, adverse reactions, short- and long-term considerations, and many other factors. Formulary placement requirements also undermine the role of Pharmacy & Therapeutics Committees that review clinical evidence and guidelines, effectiveness, cost, and additional rationale to determine proper tier placement.

As pharmaceutical innovation has progressed and the drug market continues to evolve, the traditional viewpoint that generic drugs are the lowest-cost or highest value option is not always the case. HHS' proposed changes to drug tiering in standardized plans would not account for high-cost generic drugs on higher tiers, such as Zolpidem, Estradiol, Diclofenac Sodium, Sildenafil and Tadalafil, or whose orphan status grants a monopoly. It would also impact complicated biologics that lack competition because of the difficulty of production, or scenarios where brand drugs, such as insulin or diabetic test strips, are placed onto a lower-cost tier, including situations where competitive pressure has brought the price of brand drugs on par with non-brand drugs. This proposal would also incentivize manufacturers to raise the cost of certain drugs to take advantage of mandatory tier placement. Together, these impacts would ultimately increase prescription drugs costs, and drive-up premiums for all consumers because of limits on permissible rating variation, and result in higher deductibles due to AV constraints.

Finally, issuers would need considerable time to implement and operationalize HHS' proposed formulary placement requirements. If HHS finalizes its proposal, it should not impose the requirements before the 2025 plan year, as there is insufficient time for issuers to accommodate necessary technology and process updates and modify their formularies for 2024.

HHS requests comment on the potential to incorporate additional prescription drug tiers into standardized plans for future plan years. AHIP supports this approach and believes that additional tiers provide value to consumers and flexibility for plans to effectively manage their prescription drug costs and coverage. For example, as more biosimilars come to market, additional tiers for preferred and non-preferred specialty tier drugs could allow for more flexibility to ensure optimal patient outcomes and limit patient out-of-pocket costs. Additional flexibility for preferred and non-preferred generics and preferred and non-preferred brand drugs are other examples of ways that plans can use additional tiers to design formularies that provide greater cost-sharing incentives to enrollees and prioritize cost-effective drugs that deliver better outcomes.

Before any future changes to standardized plans are proposed and adopted it is critical for AHIP and its members to better assess final trends from the 2023 plan year. Reviewing data on enrollment numbers is essential to understand the impact standardized plans had on consumer behavior and plan selection, including who enrolled in standardized plans and how to best serve

them through future improvements to standardized plan design. For example, HHS could examine opportunities for flexibility in standardized plan design to allow for value-based arrangements and examine whether the current cost-sharing structures are popular with consumers. We recommend that HHS provide additional information about standardized plan enrollment and release a request for information to review public comment on whether these plans add value for consumers before making any additional changes to plan designs.

Recommendations:

- **Maintain flexibility for issuers to establish prescription drug tiers and do not finalize the proposed changes to drug tiering in standardized plans.**
- **Support inclusion of additional prescription drug tiers in standardized plan design for future plan years.**
- **Review and assess the impact standardized plan designs have had on consumer coverage choices and experiences before making any modifications to plan designs.**

III. Plans that Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

In 2023, HHS adopted new federal network adequacy time and distances standards for QHP issuers on the FFE. AHIP engaged Wakely Consulting Group to conduct qualitative interviews with AHIP member plans who offer QHPs in the FFE to understand the impact of these new requirements, identify areas of concern and offer suggestions for improvement.[2] Wakely identified concerns with adding providers, difficulties in contract negotiations, and needed HHS' process improvements.

First, AHIP member plans shared concerns about adding providers outside of their current provider network to satisfy the new federal network adequacy requirements. Issuers curate networks based on many considerations, such as care management, contracted rates, provider quality, and overall business goals. Similarly, providers participate in networks based on amount of membership and associated patient volume, reimbursement rates, and desire to participate in a specific market, such as Medicare versus the commercial market. Network adequacy requirements can force issuers to contract with additional providers simply to meet federal requirements, resulting in higher-than-average reimbursement rates, and raising premiums and out-of-pocket costs for enrollees. They could lead issuers to contract with providers that have higher costs or lower quality of care due to lack of care management information, out-of-network referral patterns, or other factors that are inconsistent with a plan's intended design. The report includes illustrative examples of these scenarios detailed by AHIP member plans.

[2] Wakely, Network Adequacy Report, 2023. https://www.ahip.org/resources/network-adequacy-report

AHIP member plans also shared concern about the federal network adequacy requirements' impact on provider contract negotiation. In addition to the factors included above, AHIP member plans noted significant difficulties in contracting with providers because of their affiliation with a particular health system. Many systems take an "all-or-nothing" approach to contracting, which requires the health plan to include the whole health system in a network, even in scenarios when only contracting with a small number of providers is necessary to fulfill the federal network adequacy standards. Provider consolidation continues to exacerbate this dynamic, and despite good faith contracting efforts, these negotiations remain largely unsuccessful. AHIP member plans identified difficulties in obtaining comprehensive provider data that can make contracting with providers to resolve specific network deficiencies difficult due to the lack of accurate information about specialties, location, or other data elements.

While AHIP member plans generally support network adequacy requirements and ensuring that consumers have robust access to high-quality care, the report identified several areas of concern that could have long-term consequences. Provider contracting and higher administrative burden detailed in scenarios included in the Wakely report have real impacts on higher provider reimbursement rates, increased premiums, and out-of-pocket costs. This in turn can lead to fewer plan offerings, and reduced choices for consumers. AHIP member plans also expressed concerns about enrollees receiving lower quality of care because of barriers to integrated care and care management within their health plans.

Based on the feedback from the Wakely report and further discussions with AHIP members, we have two recommendations to improve the network adequacy review process based on the first year of implementation. First, we recommend that HHS establish clear timelines for the review process. Advance notice of CMS timing and being able to anticipate feedback would improve communication and understanding of expectations, allowing issuers to respond in a timely way. HHS should identify a deadline to notify issuers whether their plan has been approved and to publish network adequacy templates as soon as possible to allow plans adequate time for submission and include options for drop down menus and inclusion of additional documentation. Second, HHS should utilize the exceptions process to time and distance standards when it is in the best interest of consumers and clearly communicate these instances to issuers. For example, issuers should be granted exceptions based on provider shortages, rural access issues, or significant geographic barriers in order to preserve access, as appropriate. Additionally, lack of consumer complaints and state regulator feedback are factors that could help inform HHS when granting exceptions is appropriate. AHIP appreciates that CMS has been receptive to feedback to date and has already incorporated preliminary feedback into the federal network adequacy review process and looks forward to working together on these additional improvements.

HHS proposes a limited exception from the requirement for issuers to use a provider network for SADPs where it would be prohibitively difficult to do so. HHS' analysis in the preamble discusses the difficulties that SADPs in rural areas can have in establishing provider networks. In

order to preserve access to coverage in these areas, we ask HHS to finalize this provision to establish a limited exception for SADP issuers and include a reference to the exception in the 2024 Letter to Issuers. We recommend HHS develop a pre-approved form for SADP issuers to request the exception and permit an abbreviated filing for subsequent years if a SADP filed the full request in a prior year.

Finally, we recommend that HHS adopt a voluntary telehealth credit toward network adequacy standards. Telehealth is a significant and growing method of care delivery, particularly during the COVID-19 pandemic, and has proven to be an effective way to expand access to high-quality care. HHS has acknowledged the benefits of telehealth and should continue to evaluate ways to improve access, particularly in rural areas or areas with significant provider shortages. The Medicare Advantage program provides a 10 percent credit for contracting with telehealth providers, and HHS should explore a similar approach with NAIC and relevant stakeholders.

Recommendations:

- **Establish clear timelines for the network adequacy review process, including a deadline to notify issuers whether their plan has been approved under the process.**
- **Provide additional flexibility in the exceptions process to allow for exceptional circumstances with clear criteria around when these exceptions are necessary to preserve access for enrollees.**
- **Finalize the limited exception from the requirement for issuers to use a provider network for SADPs where it would be "prohibitively difficult".**
- **Adopt a voluntary telehealth credit toward network adequacy standards.**

Compliance with Appointment Wait Time Standards

AHIP requests that HHS provide additional flexibility around appointment wait time standards and allow ample opportunity for stakeholder input and testing before implementation. In our comments on the 2023 Payment Notice and related Paperwork Reduction Act notice, we raised significant issues regarding issuers' ability to have an impact on wait times, especially given the significant staffing shortages that continue to plague providers. Adding provider wait time information requests will add additional burden on already overwhelmed providers and staff and will likely encounter difficulty with response rates. At the same time, issuers are still adjusting to the new processes for federal network adequacy review of time and distance standards. As detailed in the previous section, additional time is necessary to refine and improve existing processes and address outstanding issues. We encourage HHS to delay appointment wait time standards until plan year 2025 to resolve existing concerns and work with stakeholders to develop and implement new standards assessing appointment wait time.

There are many outstanding details regarding the assessment and attestation of appointment wait times that will require definition, testing, and refinement before implementation. Issuers need more specific guidance around data elements and collection methods, attestation, and compliance

processes. Appointment wait time standards are difficult to assess and reliably replicate. These metrics can also vary widely based on specific patient needs and circumstances, collection methods, or in scenarios where patients prefer to see a particular provider or specialists. Attestation of wait time standards could also raise concerns in instances where issuers cannot reliably verify that information is accurate or where conditions can change based on provider shortages or access issues. Wait time standards would also benefit from alignment with existing NCQA appointment availability standards that use business days as the reporting metric. We encourage HHS to work with stakeholders to define and develop a framework for assessing appointment wait time standards and provide opportunities for feedback.

Recommendations:

- **Delay appointment wait time standards until the 2025 plan year.**
- **Work with stakeholders to establish an appointment availability framework and test appointment wait time standards prior to implementation.**
- **Ensure that issuers have additional details about measurement and can test whether they meet compliance standards before requiring attestation.**
- **Align wait time standards with existing NCQA appointment availability standards and avoid regulatory duplication.**

IV. Essential Community Providers (§ 156.235)

While AHIP recognizes the importance of a robust network of ECPs, AHIP has concerns about requiring QHPs to contract with at least 35 percent of FQHCs and Family Planning Providers at this time. Moving from a threshold across all categories to requiring a threshold for specific categories limits issuer flexibility to account for variables such as provider shortages and distribution, enrollee population distribution, and rural access, and will make it more difficult for issuers to meet these thresholds. System-wide initiatives to address health equity and access and improve the health care workforce should continue to be one of HHS' priorities. While these initiatives are underway, we encourage HHS not to increase ECP thresholds.

AHIP also has concerns about the proposal to add Rural Emergency Hospital (REH) to the Other ECP Category. Adding REH to the Other ECP category is premature as additional time is needed to evaluate implementation efforts and provider enrollment. 2023 is the first year in which eligible hospitals can apply to convert to an REH. States must pass new laws to permit licensure and registration to accommodate this new provider type, which is still underway. Furthermore, providers are still evaluating whether to apply to convert to an REH given regulations governing key aspects of this new designation were recently finalized in November 2022 and additional guidance was released on January 26th.[3] We recommend that HHS delay this proposal to

[3] Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation. https://www.cms.gov/files/document/qso-23-07-reh.pdf

accommodate and monitor these ongoing implementation efforts and, if appropriate, repropose it for the 2025 plan year.

We also ask HHS to consider provider outreach attempts as sufficient in fulfilling ECP standards. As outlined in our comments on the 2024 Draft Letter to Issuers, issuers encountered many challenges during the 2023 QHP certification process that made it difficult to finalize contracts with high-quality providers. This included unresponsive providers, providers not contracting in good faith, and difficult decisions to contract with low-quality providers who otherwise would not meet their network standards in order to fill network gaps. In addition, there are situations where a number of clinics may be owned or operated by the same entity and make contracting decisions at the corporate level. In these cases, one denial from the entity should fulfill the good faith contracting requirements. If this policy is finalized, issuers could be forced to offer contracts to low-quality providers in situations where high-quality providers are unresponsive to issuer outreach attempts. We therefore recommend HHS consider attempted outreach as sufficient to fulfill ECP standards.

Recommendations:

- **Do not adopt new requirements to contract with at least 35 percent of FQHCs and Family Planning Providers.**
- **Delay addition of Rural Emergency Hospitals to the Other ECP Category until plan year 2025.**
- **Consider provider outreach attempts as sufficient to fulfill ECP standards.**

V. Annual Eligibility Redetermination (§ 155.335)

AHIP supports HHS' goal to ensure consumers understand and consider the most cost-effective plan options. However, we caution against proposals that could override consumer choice when a consumer's selected QHP is still available. Revising the reenrollment hierarchy to reenroll a consumer in a different QHP (e.g., silver instead of bronze) than they initially selected when their plan is still available would harm consumer choice and cause unnecessary abrasion and confusion.

Consumers actively choose their health plan for several reasons, including but not limited to net premium, provider network, and out-of-pocket costs. While some consumers may prioritize net premium over other considerations, others may choose a plan based on a specific carrier, provider network, and cost-sharing arrangements, or based on their ability to enroll in a high-deductible health plan or contribute to an HSA. This proposal assumes consumers value income-based CSRs and net premium above all other factors – and while this may be true for some consumers, it is incorrect to assume this applies to all consumers, especially those who actively select a plan that supports their own, unique health conditions.

In addition, this policy proposal does not account for situations where consumers fail to make premium payments. Many enrollees stop making premium payments because they no longer need Marketplace coverage but fail to cancel their coverage. An Exchange could cause consumer confusion and abrasion and even a tax liability if a consumer is passively reenrolled into a Marketplace plan with APTC for which they are no longer eligible.

For similar reasons, AHIP also has concerns about automatically enrolling consumers into another metal level when their QHP is no longer available. Overall, it is our preference that consumers return to the Exchange to actively make a new plan selection. Consumers who are automatically reenrolled in a metal level they did not actively select may end up confused, frustrated, and have difficulty understanding their new plan's benefits. These decisions should not be made passively, and without transparency or active consent. Consumers should be empowered through the plan selection process and given the necessary tools to make the best decisions for their health care needs.

To preserve consumer choice, HHS should improve consumer decision support tools and education around silver plans. This year, HHS added a reminder prompt to the healthcare.gov plan selection process when consumers selected a non-silver plan, notifying them they could be missing potential savings by selecting a silver plan and making them confirm their plan selection before proceeding to check-out. Tools like these ensure consumers adequately consider whether a silver plan may be the best option for them, while maintaining consumer choice over the plan selection process. HHS could also provide additional educational and marketing materials to CSR-eligible enrollees prior to Open Enrollment. For example, HHS could modify renewal notices to include language that notifies CSR-eligible enrollees that they may be eligible for lower cost plans with lower cost-sharing by selecting a silver plan. We encourage HHS to examine these options to improve consumer decision support and education.

If HHS finalizes this proposal, AHIP is concerned that existing requirements around renewal notices could cause mass consumer confusion if consumers receive two separate renewal notices with different information about their health plan selection. The Guaranteed Renewability of Coverage Requirements (45 CFR § 147.106) require carriers to send notices to members 180 days, 90 days, or 60 days prior to discontinuation or renewal, depending on specific mappings and state standards. In order to coordinate any mapping hierarchy changes with issuer renewal and change notices, issuers must receive mapping information from the Exchange well in advance of the Batch Auto-Reenrollment (BAR) process. Under current processes, consumers would likely receive one notice from their issuer prior to the reenrollment process, informing them of continued enrollment in their selected bronze plan, and a second notice from the Exchange advising them that they will be re-enrolled in a silver plan. Since this may be impossible to coordinate given current operational and timing requirements, AHIP recommends HHS allow issuers to modify renewal notices. For example, issuers could be provided a similar

renewal notice flexibility to last year, which encouraged consumers to check healthcare.gov for the most up-to-date information on net premium, deductibles, and out of pocket costs.

We also urge HHS to consider the impact of the proposed changes as a whole with the upcoming wave of Medicaid redeterminations. Implementing new non-standardized plan limits, plan marketing name requirements, and revisions to the reenrollment hierarchy would cause massive disruptions to the Marketplaces, especially as states conduct Medicaid redeterminations. We encourage HHS to consider how to sequence these proposals and their cumulative impact on the Marketplace.

Recommendations:

- **Do not automatically re-enroll consumers into an alternative QHP when the QHP a consumer selected remains available on the Exchange or when their previous QHP is no longer available.**
- **Improve consumer decision support tools to empower consumers to make the best coverage decisions for their unique health care needs.**
- **If HHS moves forward with this proposal, provide flexibility for issuers to modify renewal notices to ensure consumers have accurate and clear information.**
- **Consider impacts of Medicaid unwinding on Marketplaces and related policy proposals, including non-standardized plan limits, plan marketing name requirements, and revisions to the reenrollment hierarchy.**
- **Engage stakeholders in any future policy considerations regarding the reenrollment hierarchy.**

Requests for Information

With regard to HHS' request for information, AHIP recommends HHS maintain the current reenrollment hierarchy and empower consumers to make the best health care coverage decisions for their needs.

- AHIP opposes incorporating net premium and total out-of-pocket costs throughout the Exchange reenrollment hierarchy for future years. While the maximum out of pocket limits annual costs for enrollees, it is not a good estimate of consumers' actual out-of-pocket costs, especially for those with lower health care costs.
- AHIP opposes reenrolling consumers into the lowest cost silver plan (LCSP) in the following year if the consumer chose the LCSP in the current plan year. Individuals' health needs and circumstances change from year to year, and the enrollment hierarchies should not assume that an enrollee's reason(s) for selecting the LCSP one year would also lead them to select the LCSP the following year.
- AHIP opposes zero-dollar plan reenrollment for consumers who go into delinquency or fail to make a binder payment. There are many reasons besides affordability that a consumer might stop making premium payments or might shop for a plan but not effectuate coverage. For example, many consumers simply stop making premium

payments (instead of cancelling ACA coverage) when they become eligible for other coverage.

VI. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

HHS Risk Adjustment (§ 153.320)

Data for Risk Adjustment Model Recalibration for 2024 Benefit Year

HHS' approach to recalibrating the risk adjustment model is to use the three most recent consecutive years of enrollee-level EDGE data available at the time the draft recalibrated coefficients are published in the proposed payment notice. AHIP has concerns about the precedent of deleting coefficients in the risk adjustment model to address data anomalies. If 2020 benefit year data is unique and presents a challenge for risk adjustment model calibration because of the impact of the COVID-19 pandemic, it should not be used to recalibrate the models. In addition, issuers would benefit from greater transparency into the data used to develop HHS' options to address 2020 benefit year data in order to fully evaluate these proposals, as some coefficients for specific RXCs experienced significant decreases compared to the 2023 model coefficients. We recommend that HHS publish the individual benefit year coefficients so stakeholders can evaluate HHS' proposed options and review trends over time.

Recommendations:

- **Do not include 2020 benefit year data in the risk adjustment recalibration for the 2024 benefit year.**
- **In the future, publish the individual benefit year coefficients used to develop the proposed model.**

Request for Information: Payment HCC for Gender Dysphoria

AHIP believes that 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 continues to support federal law protections that prohibit discrimination based on gender identity, sexual orientation, or pregnancy status and strongly supports ensuring that appropriate gender-affirming care is available and accessible to enrollees. We also share HHS' commitment to ensuring benefit designs and coverage decisions reflect evidence-based guidelines and recommendations and do not restrict coverage related to gender identity.

To that end, we support HHS' consideration of addressing gender dysphoria in the risk adjustment model and believe that it could help reduce barriers to care and enrollment for LGBTQ+ individuals. We encourage HHS to work with stakeholders to determine how best to incorporate gender dysphoria into the risk adjustment model and provide necessary education in advance of its introduction to ensure that any related diagnoses are coded appropriately.

Recommendations:

- **Support inclusion of gender dysphoria in the risk adjustment model.**
- **Convene a stakeholder process to determine how to best incorporate gender dysphoria into the risk adjustment model.**

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

Collection and extraction of the Qualified Small Employer Health Reimbursement Account (QSEHRA) indicator
As noted in our 2023 Payment Notice comments on data collection, AHIP appreciates HHS' efforts to improve and increase data collection for risk adjustment purposes but continues to face significant challenges with certain data elements that are not collected or available to issuers.[4] QSEHRA data is not necessary for risk adjustment purposes, difficult to obtain, not able to be reliably distinguished by consumers when available and affects a small population of enrollees. HHS should consider alternative methods of collecting this data, such as from employers that sponsor QSEHRA plans or from the Exchanges during enrollment.

Recommendations:

- **Do not finalize the proposal to collect a QSEHRA indicator.**

Extracting Plan ID and Rating Area
In our 2023 Payment Notice comments, AHIP shared concerns about patient privacy and protecting sensitive health care information and opposed the collection and extraction of rating area, plan ID, zip code and subscriber indicator. We continue to oppose the data collection proposals finalized in the 2023 NBPP and ask HHS to reconsider these requirements. HHS has set up a distributed data environment to safeguard the transmission and storage of sensitive information for this purpose and avoid exposure of identifiable information about specific issuers or members. Our previous concerns about data collection remain and expanding data extraction to previous years will further undermine these efforts. AHIP opposes the use of this data for purposes outside of risk adjustment and believes HHS should explore alternatives for data analysis.

Recommendations:

- **Do not finalize the proposal to extract plan ID and rating area from the 2017-2020 benefit year data submissions.**

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[4] AHIP Comments on Notice of Benefit and Payment Parameters for the Individual Market, 2023. https://www.ahip.org/resources/ahip-comments-on-notice-of-benefit-and-payment-parameters-for-the-individual-market-2023

Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS-RADV) (§§ 153.350 and 153.630)

Materiality Threshold for Risk Adjustment Data Validation
Using billable months instead of premium will maintain a more consistent threshold not impacted by premium increases and eliminates the need for the materiality threshold to be updated over time. For these reasons, AHIP supports this proposed change.

Recommendation:
- **Finalize proposal to change RADV materiality threshold to 30,000 total billable member months (BMM) statewide.**

VII. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

Exchange Blueprint Approval Timelines (§ 155.106)

States and issuers require adequate time to accommodate an Exchange's transition to a different structure. These transitions demand significant operational and technical lifts, including but not limited to changes to issuer information technology systems, member communications, and marketing materials. Furthermore, states and issuers must test new processes prior to implementation to ensure a smooth transition. We are concerned that without assurance of HHS' approval of the transition well in advance, additional implementation risks will surface due to intensive implementation efforts, such as IT contracting. Even with the current deadlines, some State-Based Exchange (SBE) transitions struggled to adequately prepare for their transition and experienced extreme implementation challenges, negatively impacting both states and issuers and harming the consumer experience. Anything less than the current timeline would prove hugely burdensome to state regulators and issuers and could cause major disruption for consumers in transitioning Marketplaces.

Recommendation:
- **HHS should maintain the current Exchange Blueprint approval and conditional approval deadlines to allow issuers sufficient time to make operational changes necessary to accommodate a new Exchange structure.**

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)
AHIP appreciates HHS' efforts to promote coverage continuity. This proposal would remove unnecessary barriers that impede opportunities for greater consumer engagement and education, especially for medically underserved communities and those impacted by Medicaid redeterminations. AHIP supports this policy change and further applauds the Department's

efforts to get more Americans covered by increasing funding to Navigator organizations ahead of 2023 Open Enrollment. We look forward to working with HHS to advance policy changes that mitigate coverage gaps and support coverage transitions for individuals at risk of losing Medicaid coverage during the Medicaid unwinding period.

Recommendation:

- **Finalize proposed changes to allow Navigators, Assisters, and related personnel to provide enrollment assistance to consumers through direct contact.**

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)

AHIP supports HHS' three proposed changes to agent, broker, and web-broker processes. However, we caution against implementing any changes that create additional requirements or administrative burden for issuers in scenarios where they are not directly involved. Issuers are not directly involved in gathering and assisting consumers with data used in the enrollment process, cannot verify the accuracy of the information provided, and therefore should not have liability under any of the proposed requirements.

Recommendation:

- **Finalize the proposed provisions relating to agent, broker, and web-broker requirements, so long as it does not place any new requirements on issuers.**

Eligibility Standards (§ 155.305)

AHIP supports the proposed changes to determine an applicant ineligible for APTC only if the applicant has a Failure to Reconcile (FTR) delinquent status for two consecutive years. Extending the timeline for ineligibility determinations provides Exchanges with additional flexibility with their FTR operations, and more importantly, eliminates coverage gaps and ensures continuity of coverage for consumers.

Recommendation:

- **Finalize proposed changes to the FTR process.**

Verification Process Related to Eligibility for Insurance Affordability Programs (§§ 155.315 and 155.320)

AHIP supports HHS' proposed change to accept an attestation of household income when IRS tax return data is not available. This proposed change will help ensure continuous coverage for enrollees whose household circumstances or filing status changes or who are not required to file a tax return. Health insurance providers understand some consumers may need additional time to

obtain information related to household income. However, a blanket 60-day extension may not be necessary for all consumers and could slow application and enrollment processes. Instead, we suggest allowing Exchanges the option to extend the verification process for enrollees based on their specific circumstances.

Recommendations:

- **Finalize the proposed change to accept an enrollee's attestation of projected annual household income when IRS tax return data is not available.**
- **Provide Exchanges the option to receive a 60-day extension for verification processes.**

Special Enrollment Periods (§ 155.420)

AHIP supports policy changes that mitigate coverage gaps and maintain a stable risk pool. As such, we generally caution HHS from implementing SEPs that could have significant adverse consequences for the individual market. Constant enrollments and disenrollments undermine the stability of the individual market and could result in higher premiums and narrower networks and limit consumer choice. However, we understand exceptional circumstances such as the upcoming Medicaid unwinding period may present the need for tailored SEPs that encourage timely coverage transitions within a reasonable timeframe. We recommend HHS work with issuers to implement policy changes that encourage consumers to enroll in and maintain continuous coverage.

Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))

AHIP supports policy changes that ensure consistent access to coverage, especially for those individuals who face loss of minimum essential coverage (MEC). The proposed SEP will allow for seamless transitions to Marketplace coverage during a time when more than a quarter of the U.S. population could be disenrolled from Medicaid. We appreciate these changes will be at the option of the Exchange, and further recommend this proposal only apply to states that have elected the option to terminate Medicaid or Children's Health Insurance Program (CHIP) coverage mid-month to avoid overlapping coverage and large number of enrollees not beginning coverage on the first of the month, which is common practice. We also urge HHS to ensure coverage effective date changes remain prospective, not retroactive.

Recommendations:

- **Finalize changes to the coverage effective date rules only in states that terminate Medicaid or CHIP coverage mid-month.**
- **Do not make changes that would result in retroactive or mid-month effective dates.**

Special Rule for Loss of Medicaid or CHIP Coverage (§ 155.420(c))

AHIP is committed to helping mitigate coverage losses and gaps in coverage for those who lose their Medicaid coverage during the upcoming Medicaid unwinding period. The proposed SEP will remove unnecessary administrative hurdles and provide consumers necessary additional time to secure Marketplace coverage in the event they are unable to reenroll in Medicaid coverage without an overly long election period.

Providing ninety days to select a Marketplace plan provides needed flexibility for at-risk consumers, while maintaining the stability of the individual market. We are concerned the recently announced Medicaid Unwinding SEP could have severe long-term consequences for issuers and consumers and are still evaluating the impact of this guidance.[5] Enacting a16-month open enrollment period puts creates incentives for consumers to defer coverage until July 2024; encouraging consumers to only enroll in coverage when they need care. We look forward to working with HHS promote policies that help consumers apply for and enroll in subsidized Marketplace coverage in a timely manner.

Recommendations:

- **Finalize the proposal to allow Exchanges the option to implement a new SEP for consumers who lose Medicaid coverage.**
- **Adopt SEP with an immediate effective date to provide more opportunities for coverage continuity.**
- **Consider risks associated with Medicaid Unwinding SEP.**

Plan Display Error Special Enrollment Periods (§ 155.420(d))

HHS should implement policies that encourage consumers to enroll in and maintain continuous coverage. Changes in provider networks occur frequently and often with little notice to issuers. Despite these challenges, issuers are prepared to respond to network disruptions to ensure consumers have consistent access to high-quality providers and facilities. Network disruptions do not change the value of the health plan, as issuers adapt their networks to changing circumstances. Furthermore, existing QHP and *No Surprises Act* continuity of care provisions protect consumers from disruptions in care by requiring notice of network changes and permitting enrollees to continue care with out-of-network providers under certain circumstances. Permitting consumers to change plan selections based on semi-regular occurrences could have significant adverse consequences for the individual market.

Recommendation:

- **Do not adopt a new SEP based on provider contract terminations.**

VIII. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

[5] https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf

FFE and SBE-FP User Fee Rates for the 2024 Benefit Year (§ 156.50)

AHIP appreciates the insight that HHS provides in the preamble related to calculation of issuer user fees and relevant factors, including enhanced premium tax credits, enrollment projections, transition to State-based Exchanges, Section 1332 waivers, medical inflation, and other developments. We support HHS' proposed rates and agree with HHS' rationale that sufficient funding is available to lower the user fee rates while continuing to fund Exchange operations and activities at a consistent level.

AHIP reiterates our previous comments that HHS should consider a per member per month (PMPM) user fee to better align with increasing enrollment and to promote affordability and avoid higher fee amounts based solely on premium increases. AHIP also continues to urge HHS to offer additional transparency about the use of issuer user fees, the HHS methodology in determining user fees, and how issuer user fees support HHS' policy goals for the Exchanges.

Recommendations:

- **Finalize the 2024 user fee rates as proposed.**
- **Consider an alternative user fee methodology, such as a per member per month (PMPM) amount rather than percentage of premium.**

Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)

AHIP supports the Department's goal of ensuring consumers have accurate, up to date information during the plan selection process. Issuers often name their plan after a valuable feature the plan offers, such as zero-dollar premiums. Issuers believe these naming conventions help consumers more easily identify plans that are of value to them – not mislead them.

However, AHIP acknowledges instances where plan marketing names may mislead consumers. Additional oversight of plan marketing names could reduce consumer confusion and build confidence in the plan selection process. While we support this effort, we have concerns with how HHS may implement this policy.

First, we caution against including additional requirements during the QHP certification process. New requirements would add significant administrative burden during a time when issuers are working to implement several new standards and requirements.

In addition, the proposed policy would require all information included in plan and plan variation marketing names relate to plan attributes in the Plans & Benefits Template. However, the Plans & Benefits Template has limitations, as it does not capture key benefits and details that consumers may be searching for during the plan selection process. For example, the template

currently does not capture benefits such as virtual care or benefits aimed at addressing social determinants of health, such as free transportation. As such, we recommend against adopting strict implementation standards, specifically those that require all information related to plan attributes to correspond in materials submitted as part of the QHP certification process since some of these materials have limitations and do not adequately capture all of a plan's benefits.

Furthermore, several states already regulate plan marketing names and have detailed requirements regarding what plans can and cannot include in their marketing names. Issuers work with states to ensure these requirements capture plan differences and provide meaningful information to consumers about plan benefits. We urge HHS to defer to states with adequate marketing standards, rather than adopting duplicative requirements in those states.

To better communicate important plan benefit information to consumers, HHS should improve the healthcare.gov plan display. Issuers work to ensure that consumers have the necessary tools to make informed decisions when selecting a health insurance plan by appropriately detailing plan benefit design, cost-sharing requirements, and other features in the plan details page on healthcare.gov. However, these details are not always displayed in a clear manner on healthcare.gov and are sometimes difficult for consumers to locate. For example, a consumer may not be aware that a certain plan covers primary care visits since they would have to scroll and/or click through three different display topics before reaching that information (1. Plan Details, 2. Expanding Costs for Medical Care, and 3. View Limits and Exclusions). The inability for issuers to effectively communicate key plan benefits through the healthcare.gov display can lead consumers to misunderstand plan benefits and miss out on plans that may be better fit for their health needs. The healthcare.gov display should be refined to ensure that consumers can understand the different innovative features that differentiate plans without having to include these features in the plan name. We recommend HHS convene stakeholders to evaluate ways to improve the healthcare.gov plan display, including providing a designated space within the standard viewing pathway for issuers to highlight key plan benefit or displaying complex cost-sharing structures on the initial plan view. If HHS finalizes this proposal, we recommend HHS provide additional materials and examples to clarify the plan marketing name requirements.

Recommendations:

- **Caution against including additional requirements in the QHP certification process to avoid unnecessary administrative burden.**
- **Defer to state marketing requirements, where applicable, to avoid duplicative requirements.**
- **Do not adopt strict implementation standards that require all information related to plan attributes to correspond to materials submitted as part of the QHP certification process, as some of these materials have limitations and do not adequately capture all of a plan's benefits.**

- **Improve the healthcare.gov plan display so consumers have easy access to important information about plan benefits.**
- **If finalized, provide additional clarity and specific examples of acceptable and unacceptable marketing names.**

Termination of coverage or enrollment for qualified individuals (§ 156.270)

Issuers support ensuring consumers have timely information about their health care coverage. However, issuers need sufficient time to process enrollee payments received in the few days before and after a payment due date to ensure consumers do not unnecessarily receive a notice of payment delinquency. As such, we propose a timeliness standard for sending a notice of payment delinquency of 10 business days from the discovery of the delinquency.

We propose the standard start on the date from which the delinquency is discovered to allow flexibility for situations in which premium payments are returned due to insufficient funds. Often, banks do not advise issuers of the insufficient funds until several days past the date of payment. For example, some issuers received notice of insufficient funds 20 days after the date of payment. Adopting a standard of 10 business days would allow issuers to have additional time and information related to payment delinquency and communicate more effectively with enrollees.

Recommendation:

- **Adopt a timeliness standard of 10 business days from the discovery of the delinquency.**