ACHP
ALLIANCE
OF COMMUNITY HEALTH PLANS

January 27, 2022

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via www.regulations.gov

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (CMS-9911-P).

Dear Administrator Brooks-LaSure:

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to submit recommendations in response to the proposed HHS Notice of Benefit and Payment Parameters for 2023 to support enhanced consumer experience and greater competition and efficiency in the marketplace. In this letter, we provide comments on provisions related to standardized plan options, adjustments to actuarial value methodologies, network adequacy changes, and new requirements related to data collection measures.

ACHP is a national leadership organization bringing together innovative health plans and provider groups that deliver affordable, high-quality coverage and care. ACHP member companies are non-profit community-based, provider-aligned health plans that provide coverage in all lines of business for more than 24 million Americans across 36 states and the District of Columbia. Our member health plans are leading the industry in practical, proven reforms around primary care delivery, value-based payment and data driven systems improvement.

ACHP is committed to a highly functioning and stable individual and small group market, expanding consumer access to high quality, affordable coverage and care. Consumers deserve a robust market with fierce competition and broad choice. We offer recommendations to ensure consumers are informed on the options available to them. We value the proposals to minimize the number of significant regulatory changes and provide states with a more stable and predictable regulatory framework and share the view that these proposed changes would further the Administration's goal of advancing health equity by addressing health disparities that permeate our system.

Standardized Plan Options

ACHP recommends CMS modify or remove the proposal to require plans to offer standardized plan options to complement non-standardized. In the interest of assuaging consumers who may feel overwhelmed by the plethora of options, the proposed notice requires all issuers to add standardized

options to their offerings, at every metal level, every rating area and within every network design. Contrary to its intent, this measure would increase the number of plan options in the Marketplace and confuse consumers confronting a wider array of new options. Furthermore, this proposal would impose a significant burden on issuers, as they navigate a small window to file and implement plan options.

Without refinement, the proposed notice has the potential to create a range of plans with higher premiums compared to non-standardized options. For instance, the proposed notice considers a differential or preferred display for standardized plan options on Healthcare.gov, a tactic that could, depending on how it is operationalized, lead to consumers selecting less affordable coverage options especially if the standardized plan options are displayed first or in an outsized way on the website. We believe that consumers should be able to override this default setting and select or sort all plans on any of the common features such as price, metal tier, quality ratings, issuer, etc. This ensures that consumers are easily able to find plans that best meet their needs.

ACHP sees policy dissonance between the proposed notice's objectives to provide consumers with fewer, better plan choices and its requirement that all plans offer more options. We believe this discord can be mitigated by finalizing a policy that promotes fewer and better plan choices but stops short of mandating new and additional plan options for every issuer. Additionally, we recommend providing issuers with the option to amend a 2022 plan at renewal to meet the 2023 standard plan requirements instead of adding an additional plan, provided that the plans meet the uniform modification standards.

ACHP urges CMS to limit proposed changes to Actuarial Value (AV) methodologies to provide consumers with stable and consistent plan choices. The proposed notice's changes to the actuarial value (AV) calculator methodology, while well-intentioned, are antithetical to improving the consumer experience. ACHP member companies receive regular feedback from consumers that they prefer stable, constant plan choices year over year, which they assert improves the "shopping" or plan comparison and selection experience. Fluctuations in the AV will force ACHP member organizations to make changes and adjustments that complicate the consumer experience and further clutter an otherwise standardized, stable and user-friendly plan comparison process. These changes could also force plans to eliminate popular options.

We also express concern with the application of different de-minimis ranges on actuarial value for on-exchange individual silver plans versus off-exchange individual silver plans and with setting the floor at 0% allowable variance for on-exchange individual silver plans. We believe that applying different de-minimis standards will be destabilizing to the market and may adversely impact consumers who choose to buy their plan off-exchange. The rules and requirements for plans should be the same on- and off-exchange to ensure uniformity and preserve consumer choice

Network Adequacy

ACHP recommends that appointment wait time proposals are postponed until a national strategy requiring provider self-reporting is implemented. We believe the proposed notice's goal of reducing appointment wait times is laudable. However, issuer monitoring and enforcement of contracted provider conduct presents significant operational challenges. Especially during the Public Health Emergency (PHE) and in the wake of a national provider shortage, we recommend that this proposal not be finalized. Like the consumers we serve, ACHP member organizations are overwhelmed by variation in

wait times but are not, in the current environment, able to fix them without a dedicated national solution across all coverage types requiring providers to self-report.

ACHP urges that proposals to improve Network Adequacy should be reconsidered. Especially time and distance, as it is an ineffective measure of network adequacy. Introducing time and distance standards requires health insurers, particularly those that serve rural communities to enhance their network without any added benefit to the member. Adhering to time and distance standards will not introduce added flexibilities for individuals living in these areas because there is not a significant population to warrant support for specific specialties (e.g., neurosurgery). Time and distance standards have the potential of creating bare counties where no issuers are able to serve because of the inability to meet time and distance standards. Consumers residing in those counties that rely on the Marketplace for health insurance needs may find themselves without any options if these standards are imposed on issuers. We recommend that any time and distance standards take effect no sooner than the 2024 plan year to provide issuers sufficient time to assess networks and contract with providers and facilities.

ACHP recommends that CMS postpone proposals to require issuer tracking of telehealth offerings until federal databases are established. Requiring issuers to provide information about the specific telehealth offerings of individual providers presents unique challenges, since providers vary in how and what specialties they offer via virtual technology. The proposal to require issuer tracking of provider telehealth clinical practices, which are rapidly evolving, would be difficult for issuers without a "grace" period or a willingness in the final rule to accept partially complete data. In short, without a national or federal construct in which both issuers and providers can manage information about clinical practices and telehealth availability, this specific proposal appears unworkable.

Data Collection

ACHP urges CMS to not finalize data collection proposals. The timeframe in the proposed notice requesting EDGE data is not sufficient for use in a meaningful way. Discerning and confirming Individual Coverage Health Reimbursement Arrangement (ICHRA) status is an indicator that will present significant complications for most issuers. We recommend that the proposed rule not finalize this provision for 2023 and instead engage in discussion with carriers and employers on the best way to capture this information.

Essential Health Benefits

ACHP requests more clarity on proposals to refine the EHB nondiscrimination policy. The proposed notice suggests refining CMS regulations and providing examples that illustrate presumptive discriminatory plan designs, such as discrimination based on age, health conditions and sociodemographic factors. Currently, CMS rules provide that an issuer that does not provide essential health benefits "if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."

ACHP supports both current law and the proposed notice's refinement relating to presumptive findings of discrimination. However, we believe the final rule should describe the intent for this provision more completely and settle questions relating to whether any deviation at all not based on clinical evidence is noncompliant, and whether the proposed notice's suggestion is for issuers to revisit existing EHB

mandates for preventive services and update them to provide broader coverage for all consumers, or something else unspecified.

Furthermore, the implementation timeframe is not feasible. Sixty days from publication of the final rule is an insufficient amount of time to understand and implement the new guidance and framework. Issuers will need time to work with their state(s) to assess existing requirements and evaluate and implement any changes to benefits, contracts, rates, and any other filed materials. Additionally, issuers will need time to assess existing networks and account for any new benefits or additional utilization. We recommend an effective date of plan year 2024 or later.

We certainly support requiring a robust offering of preventive services, and we reject discrimination, in whole or in part, in any aspect of benefit design. We believe that a policy more closely tracking recommendations and guidance from the United States Preventive Services Task Force (USPSTF) to covered preventive services that are explicitly referenced in the preamble to the rule, would provide the protections for consumers the proposed notice seeks, while also simplifying compliance among issuers. Furthermore, by tracking closely to the USPSTF, issuers will have adequate time to develop new contracts, provide services, and collect data on efficacy.

ACHP appreciates the opportunity to comment and provide recommendations on these important policies for consumers and issuers for the plan year 2023. Please contact Nissa Shaffi, Associate Director of Public Policy at nshaffi@achp.org with any questions or to discuss these recommendations further.

Regards,

Ceci Connolly
President and CEO
ACHP