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December 18, 2015

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: Proposed Rule: CMS-9937-P/RIN 0938-AS57 Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017 (Vol. 80, No. 231, December 2, 2015)***

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule establishing the 2017 benefit and payment parameter standards for health insurance issuers and the Health Insurance Marketplaces. The proposed rule includes changes to many standards, including provisions related to network adequacy, acceptance of third-party payments by qualified health plans, essential health benefits, consumer assistance programs, medical loss ratio, enrollment, and payment parameters, such as risk adjustment, reinsurance and risk corridors. The rule also proposes changes to patient safety standards, which we will address in a separate letter.

The AHA appreciates CMS's efforts to fine tune and improve implementation of the insurance provisions contained in the Affordable Care Act (ACA); continuous evaluation is important to resolve issues as they arise. **As such, we support many of the proposed changes, including those regarding network adequacy standards and exchange establishment standards, but have concerns with several other provisions, such as acceptance of third-party payments by qualified health plans and medical loss ratio standards. Our detailed comments follow.**



**QUALIFIED HEALTH PLAN (QHP) MINIMUM CERTIFICATION STANDARDS (SECTION 156.200 – SECTION 156.1250)**

Our comments below address Marketplace standards for QHPs including network adequacy, essential community providers (ECPs), three-month grace period and third-party payment of QHP premiums.

*Network Adequacy*

**The AHA supports CMS’s efforts to strengthen QHP provider networks by proposing new network adequacy standards, such as time and distance requirements. We recommend that CMS apply these proposed standards not only to QHPs sold in the federally-facilitated exchanges (FFE), but also to QHPs sold in state-based exchanges (SBE).** The AHA strongly believes that patients and providers are best served when: 1) there is sufficient choice of providers; 2) care is easily accessible; and 3) patients and providers clearly understand their financial obligations when care is provided in or out-of-network. To that end, the AHA has been actively engaged in and supportive of the National Association of Insurance Commissioners’ (NAIC) process to update its provider network adequacy standards. While the NAIC has completed its work and states are deciding how to move forward in their consideration of the recommendations, the AHA believes that CMS has a unique opportunity to play a leadership role in establishing strong network adequacy standards, including quantitative measures. The proposals contained in this rule are a good first step in that direction.

Minimum Federal Threshold. **The AHA supports CMS’s proposal to establish a minimum federal threshold to determine if QHPs have provider networks that meet the ACA network adequacy standard.** Specifically, CMS proposes that networks should be sufficient in numbers and types of providers, including specialists in mental health and substance abuse, to ensure services are accessible and available without unreasonable delay. CMS states that it will provide further guidance on the specific criteria in future annual letters to issuers. In addition, the agency notes that, for the draft Letter to Issuers for Plan Year 2017, it expects to include time and distance standards and provider-to-covered-person ratios for specialists with the highest utilization in the state, which we support. The proposed rule also requires that states with standards that exceed the minimum federal threshold affirmatively apply those standards in their review of provider networks.

**While the AHA generally supports the use of time and distance standards for provider networks similar to standards used by the Medicare Advantage (MA) program, we encourage CMS to allow for the special circumstances and unique medical needs of children and adults with complex and chronic medical conditions.** These complex patients may need more immediate and frequent access to certain specialty providers than is accommodated by a uniform time and distance standard. For

example, a recent Avalere study noted that QHP networks included 42 percent fewer oncology and cardiology specialists than average commercial plans.<sup>1</sup>

As the agency seeks to align network adequacy standards between QHPs and MA plans, the AHA also encourages CMS to consider the network adequacy standards proposed for Medicaid Managed Care plans.<sup>2</sup> For these plans, the AHA supported CMS's use of time and distance standards that specified consideration of a range of provider types, from primary care physicians and other practitioners to hospitals, as well geographic location of providers, the health needs of the population, the numbers and types of health providers, whether providers are available to accept new patients, and the need for special accommodations such as disability and/or limited English proficiency. In addition, the AHA also encourages CMS to thoughtfully consider the NAIC's newly adopted Model Act #74 on provider network adequacy standards. While the NAIC Model Act serves as a framework for states to follow, the network adequacy standards outlined are the result of extensive stakeholder engagement.<sup>3</sup> Specifically, the NAIC Model Act includes other measures, such as wait-times for appointments and hours of operation, to assess provider network sufficiency.

**However, when considering QHP issuers' use of tiered networks, the AHA strongly urges CMS to go beyond the NAIC Network Adequacy Model Act #74. Specifically, we recommend that CMS apply all network adequacy standards to the lowest cost-sharing tier of any tiered network to prevent discriminatory or inadequate plan designs.** We are concerned that providers that may subspecialize and care for patients with more complex needs may be placed only into higher cost-sharing tiers, forcing patients (both children and adults) who need to access these providers to pay significantly more out-of-pocket even though such care is a covered benefit. The widely understood objective of cost-sharing is to influence certain consumer decisions. However, if there are not appropriate providers – primary, specialty and subspecialty care for children and adults – available in the lowest cost-sharing tier, the additional cost-sharing associated with providers in a higher tier becomes discriminatory and costly to the consumer. Therefore, we recommend that the lowest cost-sharing tier include a full range of providers for all covered services. Indeed, some states already have adopted requirements to protect consumers from possible discrimination in the design of tiered networks.<sup>4</sup>

**Out-of-Network Cost-sharing Services Provided at In-network Locations. While the AHA is encouraged that CMS is looking to extend protections for consumers that receive covered services by out-of-network providers, we believe CMS's proposals fall short.** Specifically, CMS proposes to require that QHP issuers count cost sharing for out-of-network providers toward the annual limit on cost sharing when the enrollee receives an essential health benefit at an in-network location. Alternately, the issuer could

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<sup>1</sup> Exchange Plans Include 34 Percent Fewer Providers than the Average Commercial Plans, [www.avalere.com/expertise/managed-care/insights/exchange-plans-include-34-percent-fewer-providers-than-the-average-for-comm](http://www.avalere.com/expertise/managed-care/insights/exchange-plans-include-34-percent-fewer-providers-than-the-average-for-comm), Avalere Health LLC, July 2015.

<sup>2</sup> AHA July 23, 2015 letter to CMS on Medicaid Managed Care Proposed Rule.

<sup>3</sup> AHA, October 29, 2015, letter to NAIC Chairs of Health Insurance Managed Care (B) Committee

<sup>4</sup> Hancock, Jay, *Narrow Networks' Trigger Push-Back from State Officials*, Kaiser Health News, Nov. 25, 2013 <http://khn.org/news/states-balk-at-narrow-networks/>

provide a written notice to the enrollee at least 10 business days before the person receives the service that additional costs would be incurred if they were to use an out-of-network provider in an in-network setting and that any cost-sharing incurred would not count toward the enrollee's annual limit. However, because the current regulatory definition of cost sharing excludes balance billing, CMS's proposals would provide little financial protection for consumers facing unexpected medical bills resulting from out-of-network providers at in-network facilities. **Therefore, the AHA recommends that CMS look to NAIC's Model Act #74, which offers the consumer greater financial protections from unexpected bills through a structured mediation process between the health plan and the out-of-network provider.**

Continuity of Care. **The AHA supports CMS efforts to provide consumers greater continuity of care protections in the event their provider is no longer part of their QHP network.** Specifically, we support CMS's proposed requirement that QHP issuers make a good faith effort to notify enrollees when their provider is being discontinued from the network. However, we urge CMS to require that these notices include information about enrollee rights to transitional care from their provider if they are in the midst of an active course of treatment. In terms of the definition of active treatment, the AHA urges CMS to look to the NAIC definitions that include second and third trimester pregnancy and a post-partum period, as well as terminal illness and end-of-life care that may extend beyond the CMS's proposed 90-day care transition period.

Essential Community Provider. **The AHA is very concerned that CMS has chosen not to disaggregate certain ECP categories to ensure better access to a wider variety of health services.** Specifically, in its Final Rule for the Benefit and Payment Parameters for Plan Year 2016, the agency stated it was considering disaggregating children's hospitals and other clinics and health centers. However, in the proposed rule, CMS has now taken the position that there are not enough ECP children's hospitals in their own ECP database to provide issuers with sufficient contracting flexibility. However, we believe this conclusion is based on inaccurate data. Specifically, the Children's Hospital Association will soon be sharing with CMS their analysis of the ECP database that found several sources of inaccuracies, such as children's hospitals that are inaccurately identified as adult hospitals. **Therefore, the AHA recommends CMS work to improve the ECP database and include the disaggregation of children's hospitals in the final rule, which will help ensure that children have access to the care they need through broader QHP provider networks.**

Termination of Coverage or Enrollment and the Three-month Grace Period. **The AHA generally supports CMS's clarification that, if an enrollee fails to make premium payments and loses premium assistance eligibility, the enrollee is eligible for the three-month grace period during which health plan services will continue to be available.** The AHA also supports CMS's clarification that the QHP issuer can take into account a premium payment *de minimis* threshold before terminating coverage when the remaining payment is for a nominal amount. These are important clarifications that protect an enrollee's access to coverage. **However, we continue to urge CMS to require that health plans pay providers for any and all care that is rendered during**

**the entire three-month grace period.** As it stands now, health plans are only required to pay for the first 30 days of the grace period, leaving the last 60 days as uncompensated care that is provided by hospitals and other providers.

Rating of QHP Relative Network Coverage and Tiering Selection Criteria. CMS notes that it is considering rating each QHPs on its relative network coverage and posting the rating on [healthcare.gov](http://healthcare.gov). **While the AHA supports initiatives that provide consumers with more information on a QHP's breadth of coverage, we recommend that CMS work with all stakeholders in developing a rating system to ensure that it provides not only greater transparency, but also meaningful information.** In addition, CMS seeks comment on whether QHP issuers that use tiered networks should provide the standards they use for selecting and tiering providers. The NAIC Model Act #74 requires health plan issuers to include in their access plans filed with the state insurance commissioners and in their published provider directories information on the criteria they use to select and tier providers. **Consistent with that, the AHA supports CMS efforts to provider greater transparency regarding the criteria health plans and issuers use to select and tier providers in their network plans.**

*Third-party Payment of Qualified Health Plan Premiums*

Under existing rules at §156.1250, CMS requires QHP issuers to accept third-party payment of premiums from Ryan White HIV/AIDS Programs; Indian tribes, tribal organizations or urban Indian organizations; and state and federal government programs. In the final rule adopting the regulation, CMS explicitly encouraged QHPs to reject third-party payments from hospitals, other health care providers and commercial entities. In this proposed rule, CMS announced that it is “considering whether we should expand the list of entities from whom issuers are required to accept payment [under the regulation] to include not-for-profit charitable organizations in future years.”

**The AHA urges CMS to act now and in the final rule require QHPs to accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations, just as they are required to accept these payments from the Ryan White HIV/AIDS program.** Any effort to limit the ability of hospitals or hospital-affiliated foundations and other charitable organizations to help individuals in need obtain access to health insurance coverage is bad public policy. Not only does it undermine one of the core objectives of the ACA – making affordable insurance coverage available to the uninsured – it also adversely impacts those who need it most, the poor and sick. The entire Marketplace approach is based on the notion that any individual (with limited exceptions for incarcerated individuals and undocumented immigrants) can choose to purchase any QHP offered through an exchange. As long as the premium for that plan is paid, the insurer has to accept that individual and enroll him or her in the chosen plan (again, with limited exceptions). As in any other commercial market, it should not matter who actually pays the insurance premium – the enrollee, the enrollee's relative or another person or organization.

Hospitals have engaged in significant efforts to assist individuals with enrollment in QHPs. It has been their experience that, even with federal subsidies, cost can be an impediment to an individual obtaining coverage and the access it provides to important

preventive and other health services. A recent *New York Times* article highlighted how sky-high deductibles are creating financial strain for consumers on the exchanges.<sup>5</sup> Hospital and foundation subsidy programs are especially important for individuals residing in states that have chosen not to expand their Medicaid programs and could help fill the gap in making affordable coverage available to meet the needs in those communities. Moreover, discouraging QHPs from accepting hospital-provided subsidies is at odds with the position repeatedly espoused by the administration that insurance coverage is far preferable to a patchwork of treatment, most often accessed by the uninsured through the emergency department. CMS's rationale in requiring QHPs to accept Ryan White HIV/AIDS program subsidies applies equally to requiring the acceptance of payments from hospitals, hospital-affiliated and other charitable organizations: "a delay in coverage for people who rely on ... third parties ... to pay their premiums could result in worsening medical conditions."

CMS has offered no explanation, facts or other evidence to support its purported concerns that premium assistance to uninsured individuals "could skew the insurance risk pool and create an unlevel field in the Marketplaces." There is no need to further delay requiring QHPs to accept premium support from hospitals, affiliated foundations and other charitable organizations. Incorporating two conditions applied in the Feb. 7, 2014 FAQ would address the agency's stated interest in "guardrails" – 1) subsidies would be awarded based on financial need; and 2) the premium or cost-sharing payments would cover the entire policy year (which should be clarified to include the balance of a premium year in the event the need for financial support arises during a policy year). There should be no general prohibition on consideration of the enrollee's health status (a factor included in the FAQ). When allocating limited resources among those with a financial need, it is appropriate and logical to also include consideration of the medical needs of each individual.

We note that CMS has stopped short of attempting to prohibit hospitals and other providers from furnishing premium and cost-sharing payment assistance through a regulation. Indeed, we believe the agency lacks authority to adopt such a prohibition. In fact, the regulations implementing the federal premium tax subsidy clearly contemplate that, in many cases, another person or organization might pay the premium for an individual to enroll in a QHP. For purposes of determining whether an individual is eligible for a federal premium tax credit for a given month, the regulations provide that premiums paid by "another person," such as by another individual or by an Indian tribe, are treated as "paid by the [enrollee]." In other words, an individual enrolled in a QHP can be eligible for a federal subsidy if another person pays for that individual's insurance premium. Thus, it is contrary to the regulations to encourage insurers to reject premium payments made by certain third parties on behalf of individuals enrolling in that insurer's QHP. (Hospitals recognize that they would still need to ensure that involvement in the process of assisting a patient to enroll in a QHP is consistent with federal and state law, including health privacy and conflict of interest rules.)

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<sup>5</sup> Pear, R. "Many Say High Deductibles Make Their Health Law Insurance All But Useless," *New York Times*, Nov. 14, 2015.

Finally, in encouraging insurers to reject premium subsidies paid by hospitals and other providers, CMS is arguably advocating a policy that is inconsistent with yet another core principle of the ACA – the prohibition of discrimination against individuals with certain diseases, conditions or other significant health care needs. As CMS is well-aware, uninsured individuals who are otherwise qualified to purchase insurance through the Marketplaces, but who have certain debilitating diseases or conditions, may not be able to afford health insurance, even after any federal subsidy. Those individuals would likely benefit from premium subsidies paid on their behalf. By encouraging insurers to reject premium subsidies paid by hospitals on behalf of such individuals, CMS is effectively condoning the exclusion of the disabled from coverage.

The AHA and its members will continue to work to enable as many Americans as possible to obtain health care coverage, especially those with limited resources who have no other means of coverage. We urge CMS to remove the impediments it has created for hospitals to achieve that goal.

#### **HEALTH ISSUER STANDARDS AND ISSUER USE OF PREMIUM REVENUE INCLUDING REPORTING AND REBATE REQUIREMENTS (SECTIONS 156.122, 158.103, 158.140 (A))**

Our comments below address standards for health issuers including essential health benefits and Medical Loss Ratio (MLR).

Essential Health Benefits and Opioid Addiction. **The AHA strongly recommends that CMS clarify that the substance use disorder coverage requirement that is part of the current QHP essential health benefit package include medication-assisted treatment of opioid addiction.** Expanding use of medication-assisted treatment of opioid addiction is one of three key initiatives the Department of Health and Human Services announced in March 2015 to reduce opioid and heroin related overdose, death and dependence – initiatives that the AHA strongly supports.

Medical Loss Ratio. **The AHA supports CMS’s proposal to improve the accuracy of MLR calculations by requiring issuers to use six months of reported incurred claims. However, the AHA opposes allowing health insurers to use investments in fraud prevention activities as an incurred claim for purposes of the MLR calculation.** The NAIC considered allowing fraud activities as incurred claims several years ago, but instead allowed health insurers to offset fraud recoveries against claims. Including fraud prevention activities as a costs in the numerator of the MLR calculation could artificially increase a plan’s MLR, thereby conveying an inaccurate picture of how much of the premium dollar a plan is actually spending on health care services.

#### **EXCHANGE ESTABLISHMENT STANDARDS (SECTIONS 155.200, 155.205, 155.335 AND 155.605)**

Our comments below address standards relating to the new Marketplace model that uses the federal platform for certain functions, consumer assistance programs, re-enrollment and hardship exemptions for individual responsibility.

**Federal Platform. The AHA supports CMS’s proposed Marketplace model that would allow SBEs to use the federal system for certain Marketplace functions such as eligibility, enrollment, consumer call center and case work functions and information technology infrastructure.** The new model, known as State-based Exchange on the Federal platform (SBE–FP), would give states more options in running and maintaining complicated enrollment and eligibility information systems. CMS also proposes to fund this new model by requiring QHPs to pay a user fee. The AHA urges CMS to carefully consider the size of the QHP when establishing the user fee payment to avoid any undue burden on smaller QHPs, especially provider-based QHPs, from entering the new SBE-FP.

**Consumer Assistance. The AHA is generally supportive of CMS’s proposal to expand the role of Navigators to provide targeted assistance to underserved and vulnerable populations as defined by the Marketplace.** Navigators also would be required to provide post-enrollment assistance including on eligibility appeals, reconciliation with premium tax credit assistance and assisting in health care insurance literacy. The other Marketplace consumer assister programs would not be required to take on these new responsibilities, but they would be encouraged to add as many as are appropriate. The AHA urges CMS, as it considers expanding the role of the Marketplace Navigator, to consider the additional financial cost for these new responsibilities.

**Re-enrollment Hierarchy. The AHA urges caution with regard to CMS’s proposal for automatic re-enrollment of enrollees.** Maintaining access to preferred providers is critically important for some plan enrollees, often more important than the premium level, especially for those engaged in ongoing care. Yet, CMS’s proposal would require enrollees currently in a silver plan and receiving cost-sharing subsidies to be placed in another silver plan by the same issuer if the original silver plan is no longer available. **The AHA recommends that any set of re-enrollment hierarchies clearly articulate the options that best ensure the enrollee will retain access to his or her existing providers.** With the growing number of network variations available in many markets, simply maintaining coverage from the same insurer will not guarantee maintenance of network providers.

**Hardship Exemption. The AHA supports CMS’s proposal to simplify, for those individuals living in states that have not expanded their Medicaid programs, the process for seeking an exemption from the ACA’s individual responsibility requirement.** Specifically, under CMS’s proposal, individuals seeking a hardship exemption would no longer have to undergo an eligibility determination for Medicaid. The Marketplace instead would be able to determine that the individual “would have been eligible for Medicaid,” allowing the individual to claim an exemption on his/her federal tax return instead of seeking an exemption certificate from the Marketplace.



**STANDARDS RELATED TO RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS AND HEALTH ISSUER RATE DISCLOSURE AND REVIEW (SECTIONS 153.320, 153.510, 153.530, 154.200-154.301)**

**Risk Adjustment and Reinsurance. The AHA supports CMS’s proposal to update the risk factors used in the risk adjustment methodology with more current data, as well as incorporate preventive services and prescription drug information.** The risk adjustment program is a permanent element of the ACA market reforms designed to mitigate risk for issuers in the individual marketplaces. The other risk mitigation programs reinsurance and risk corridor programs – conclude at the end of fiscal year (FY) 2016. **While the risk reinsurance program ends in FY 2016, the AHA supports CMS’s proposal to make certain that any remaining reinsurance amounts are paid out for the 2016 benefit year.**

**Premium Rate Disclosure. The AHA supports CMS’s proposal to increase transparency in the issuer rate setting process to provide the public with more comprehensive information.** Specifically, CMS proposes to require that health plan issuers submit a unified rate review template for all single risk pool products in the individual and small group markets, regardless of any change in the rate. CMS further proposes to include on healthcare.gov the proposed rates for all health plan issuers, whether they are subject to a rate review or not.

The AHA supports strong and viable health insurance marketplaces to help achieve the coverage goals of the ACA. As it relates specifically to the QHP marketplace qualifying standards, the AHA continues to urge CMS to apply provider network adequacy to all QHPs, whether they are sold in the FFE or the SBE. In the end, creating consistent rules and protections for consumers and providers will benefit all.

Thank you for your consideration of our comments. If you have any questions, please contact Molly Collins Offner, director of policy development, at (202) 626-2326 or [mcollins@aha.org](mailto:mcollins@aha.org).

Sincerely,

Thomas P. Nickels  
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