



January 27, 2022

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

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

Dear Secretary Becerra:

Thank you for the opportunity to submit comments on the Notice of Benefit and Payment Parameters for 2023 Proposed Rule, issued by the Department of Health and Human Services (“HHS” or the “Department”).

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the federal government to make the best use of the knowledge and experience our patients and organizations offer in response to the proposed rule.

In March of 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation’s healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

We appreciate the administration’s ongoing commitment to improving the accessibility, affordability, and quality of care and are confident the policies included in the proposed rule will advance these

¹ Consensus Health Reform Principles. Available at: <https://www.lung.org/getmedia/24309f63-74e9-4670-8014-d59f21104cfd/092021-ppc-healthcare-principles-42-logos-final.pdf>.

shared objectives. We respectfully offer the following comments and recommendations addressing specific provisions of the proposed rule.

Guaranteed Availability of Coverage, Past-Due Premiums

The statutory requirement that a participating issuer must make coverage available to all individuals who apply for it is a bedrock protection for the patients and consumers we represent, and for all individuals with preexisting conditions. As we have previously observed, the 2017 policy that permits issuers to deny coverage to people who the issuer says owe it, or a related entity, premiums, is inconsistent with federal law. We agree with HHS that this policy imposes a barrier to coverage for individuals who, for various reasons, might find their enrollment rejected by an issuer, and agree that individuals at low incomes are disproportionately harmed by this approach. We therefore support the proposal to revoke the 2017 policy and restore full guaranteed availability rights as provided under the ACA.

Nondiscrimination Based on Sexual Orientation and Gender Identity

LGBTQI+ people face significant challenges accessing healthcare because of discrimination based on sexual orientation or gender identity. For example, in one survey, roughly 29% of LGB respondents and 73% of transgender respondents felt that medical personnel would likely treat them differently because of their sexual orientation or gender identity.² Discrimination based on sexual orientation or gender identity impedes access to health coverage and care, worsening health outcomes and imposing additional financial costs on those who face such conduct. These harms exacerbate existing disparities experienced by LGBTQI+ individuals, and the current absence of clear federal regulatory protections against such discrimination undermines efforts to address health equity.

HHS proposes to amend six nondiscrimination provisions to prohibit explicit discrimination based on sexual orientation or gender identity.³ As HHS notes, existing law provides ample authority for the revisions, which would simply restore these vital protections to their pre-2020 scope. We strongly support these proposals.

Risk Adjustment

The proposed rule would make several changes to the individual and small group market risk adjustment program. One of those proposed changes is to adopt a “two-stage” method for estimating the parameters of CMS’ risk score models. CMS indicates that the intended effect of this change is to reduce risk adjustment payments from insurers that attract lower-risk enrollees (which, in turn, would reduce risk adjustment payments to insurers that attract higher-risk enrollees).

Because higher-risk enrollees are more likely to select higher-quality plans (e.g., plans with broader provider networks, larger formularies, or less onerous utilization controls), we are concerned that this proposal would increase the premiums of higher-quality plans. This would make it harder for consumers to afford these plans and increase premium burdens for consumers with greater health care needs.

We are also concerned that this proposal would create incentives for insurers to reduce the quality of the coverage they offer, both in general and for high-risk enrollees in particular. Those types of insurer

² https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf

³ In particular, the proposed rule would strengthen the nondiscrimination protections found at 45 C.F.R. §§ 147.104(e), 155.120(c), 155.220(j), 156.125(b), 156.200(e), and 156.1230(b).

responses would exacerbate the problems that the stronger network adequacy and nondiscrimination standards that are also included in the proposed rule aim to address. As we discussed above, we believe that the insurer behavior targeted by these standards is doing substantial harm and that CMS should refrain from taking any actions that would make these problems worse. Therefore, we oppose this proposal.

Web-broker Website Requirements and Standards for Agents, Brokers, and Web-brokers

We recognize that insurance agents and brokers, including web-brokers, can and often do work constructively to help individuals understand their health insurance options and have enrolled many in comprehensive coverage. Yet these entities are also subject to inherent conflicts of interest that are simply not present for navigators or the marketplaces themselves.⁴ Agents and brokers generally have no duty to act in the best interest of consumers and, indeed, are compensated in ways that typically do not align with consumer interests and provide a financial incentive to steer people to products that are unlikely to meet their needs. We have repeatedly urged the Department to establish and enforce rigorous standards to mitigate these conflicts and reduce consumer confusion and have voiced our opposition to policies adopted in the last administration that have increased consumers' risk of harm.

We appreciate that the proposed rule takes these risks seriously and support the proposals to (1) require web-broker websites to display additional comparative information for all qualified health plans (QHPs), consistent with what is displayed on HealthCare.gov; (2) clarify that web-broker websites are prohibited from displaying QHP advertising; and (3) require web-broker websites to prominently display a clear explanation of the rationale for how they recommend plans and the methodology for their default display of QHPs. We believe these steps will improve web-broker website transparency and reduce, somewhat, the risk that consumers will be improperly influenced during plan selection by web-broker financial conflicts. We also support the Department's proposed clarifications of standards and prohibited business practices for agents, brokers, and web-brokers. These proposals will also address some of the harms caused by agent/broker conflicts of interest, as documented by the proposed rule.

While we appreciate all of these efforts, more action is needed. HHS should prohibit agents and brokers that sell QHPs from marketing products that are not compliant with the ACA's individual market reforms (such as short-term limited duration products) during marketplace open enrollment. The Department should also consider requiring brokers, who consumers rely on for their professional experience and expertise, to act in the best interest of the individuals they serve. Agents and brokers should also have an affirmative duty to screen consumers for Medicare and Medicaid eligibility, so that individuals who qualify for such coverage are not instead routed to private insurance products, as sometimes happens now.⁵ In addition, given the risks posed by their financial conflicts, agents and brokers should be required to disclose the amount of their commissions.

Annual Eligibility Redetermination, Re-enrollment Hierarchy

The proposed rule solicits comment about whether the re-enrollment hierarchy, which governs the automatic re-enrollment of enrollees who are eligible to remain in marketplace coverage but who have

⁴ Corlette S, Blumberg LJ, Wengle E. Insurance Brokers and the ACA: Early Barriers and Options for Expanding Their Role. The Urban Institute. <https://www.urban.org/sites/default/files/publication/39571/2000091-Insurance-Brokers-and-the-ACA.pdf>. Published February 2015.

⁵ Straw T. "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>. Published March 15, 2019.

not returned to the marketplace to shop actively during open enrollment, should be modified to incorporate factors such as net premium, maximum out-of-pocket limits, deductibles, and annual out-of-pocket costs.

We strongly support the existing policy of automatic re-enrollment as an important safeguard for consumers that promotes continuous coverage and a stable individual market.⁶ Still, marketplace enrollees are usually well-served by returning to the marketplace each open enrollment period to compare their coverage options and update their eligibility information, and there is a risk that enrollees who do not do so will be automatically re-enrolled in plans with higher premiums and cost-sharing than available alternatives.⁷ For this reason, we appreciate that HHS is considering how to refine the re-enrollment process to reflect plan generosity. We believe that, in principle, a modified hierarchy that takes account of consumer costs, including costs that are in addition to premiums, will be more likely to match auto re-enrolled consumers with plans best suited to their needs. Furthermore, the examples provided in the preamble of the proposed rule appear to be generally consistent with this objective.

However, we urge caution regarding any change that could result in an individual being auto re-enrolled into a new product where the existing product remains available. For example, while re-enrollments that place a consumer into a plan with a different network type (and a different composition of providers) may be in a consumer's best interest in some circumstances — we believe ensuring continuous coverage by re-enrolling someone in a plan with a different network type is appropriate where the person's current product is being discontinued, for example — changes in an enrollee's network generally increase the chances of confusion and out-of-network costs and should be approached carefully.

Special Enrollment Period Verification

We appreciate the administration's recognition of the barriers and burdens that continue to limit enrollment in comprehensive coverage through the marketplaces. Despite generally low use of special enrollment periods (SEPs) by eligible individuals, the burdens placed on consumers who hope to access coverage under an SEP increased in the years immediately preceding the COVID-19 pandemic.⁸ We believe that making it harder to access coverage through an SEP has been counterproductive for the marketplaces and the consumers who rely on them by inappropriately deterring enrollment, both in general and with respect to younger and healthier enrollees in particular. It stands to reason that the individuals who spend the time and effort needed to overcome growing barriers to enrollment need the coverage more (i.e., they are less healthy) than those who are deterred by the process. And evidence indicates increased SEP documentation requirements have disproportionately reduced enrollment

⁶ For the effects of automatic re-enrollment on continuous coverage, see, e.g., Drake C, Anderson DM. Association Between Having an Automatic Renerollment Option and Reenrollment in the Health Insurance Marketplaces. *JAMA Intern Med.* [10.1001/jamainternmed.2019.3717](https://doi.org/10.1001/jamainternmed.2019.3717). Published September 23, 2019.

⁷ See, e.g., Anderson DM, Rasmussen PW, Drake C. Estimated Plan Enrollment Outcomes After Changes to US Health Insurance Marketplace Automatic Renewal Rules. *JAMA Health Forum.* [10.1001/jamahealthforum.2021.1642](https://doi.org/10.1001/jamahealthforum.2021.1642). Published July 16, 2021.

⁸ See Buettgens M, Dorn S, Recht H. More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods. The Urban Institute. <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>. Published November 2015.

among young adults.⁹ By contrast, we are aware of no evidence to suggest that pre-enrollment documentation requirements have had any meaningful impact on program integrity. Therefore, we support the Department’s proposal to limit pre-enrollment burdens on consumers.

User Fee Rates for the 2023 Benefit Year

HHS proposes that the 2023 user fee rates for issuers that participate on the federally facilitated marketplace (FFM) or a state-based marketplace on the federal platform (SBM-FP) will be 2.75 percent and 2.25 percent, respectively. While the proposed rates are equal to those in place in 2022, they are .25 percentage points lower than they were in 2021 and are smaller still compared with prior years.¹⁰

We are grateful for the extensive efforts undertaken by the administration to support the work and purpose of the marketplaces. This includes substantially increasing spending on consumer outreach and education, following years in which funding for these vital responsibilities shriveled. As we have in the past, we urge HHS to maintain and expand these investments, and to consider devoting additional resources to improving the HealthCare.gov interface, which would benefit consumer decision-making and facilitate enrollment for health plans. To help sustain the progress of the marketplaces and support the record number of consumers now enrolled in coverage through the portals, we suggest that user fee rates be returned to pre-2022 levels.

Essential Health Benefits: Prohibiting Benefit Substitution Across Categories

The ACA’s standards obligating insurers to cover all essential health benefits (EHB) are of fundamental importance to the patients we represent. In 2019, the prior administration granted insurers flexibility to game these standards, authorizing them to limit coverage of one or more essential benefit categories, so long as they provide other, different services that, on paper, are of equivalent actuarial value. This approach is contrary to the intent of the ACA. It invites abuse and, as HHS recognizes, poses particular dangers for people living with chronic conditions and disabilities. We strongly support the proposal to reverse the policy and again prohibit this conduct.

Essential Health Benefits: Nondiscrimination in Health Plan Designs

Insurers that must provide coverage of EHB are required by the ACA to utilize benefit designs that are nondiscriminatory. The proposed rule would refine this protection to specify that a nondiscriminatory benefit design is one that is based on clinical evidence. As we understand the new policy, limitations on benefits and other coverage decisions that lack the support of relevant, clinically based evidence would be presumptively discriminatory.

We thank the Department for its commitment to the ACA’s robust nondiscrimination framework and support the proposal to ensure that plan designs are grounded in relevant clinical evidence. We urge CMS to ensure that, in advancing the goals of nondiscrimination in plan design, the clinical evidence used is not biased or discriminatory itself. Prominent bioethicists still question whether older people, people with disabilities, and people with chronic health conditions are worth treating. Their work may be published in prestigious journals. Historically, much racist and eugenicist scholarship has been

⁹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Pre-Enrollment Verification for Special Enrollment Periods. <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf>.

¹⁰ The user fee rate for FFM issuers was 3.5 percent from 2014-2019. HHS did not charge a user fee for issuers on the SBM-FP until 2017. The fee rate for SBM-FP issuers was 1.5 percent in 2017; 2 percent in 2018, and 3 percent in 2019.

published in medical journals, and the medical research field is not yet free of racism or anti-disability bias. We urge CMS, when reviewing the clinical evidence used to defend plan design, to ensure that the evidence itself is not discriminatory in nature. We also appreciate that HHS has clearly identified several types of plan designs that are presumptively discriminatory. These examples, which include designs that thwart affordable access to benefits and services relied on by our patients, violate nondiscrimination protections as currently articulated. We urge the Department to monitor issuers for compliance with nondiscrimination requirements, as the proposed rule pledges, and to assist states with oversight and enforcement.

Actuarial Value

To facilitate consumer decision-making and promote the affordability and adequacy of coverage, non-grandfathered individual and small group market health plans must be offered only at specified levels of value. Plans at a particular value tier must adhere to the actuarial value (AV) requirements specified for the tier by law, and may not vary from the prescribed AV except by a de minimis amount.

The proposed rule would reestablish a more rigorous definition of “de minimis variation” that we believe better aligns with the language of the statute and that would advance the objectives for which the AV protections were enacted in the first place. The current, more permissive approach to what constitutes a de minimis variation in AV blurs the distinctions between the coverage tiers, significantly reducing the utility of the gold/silver/bronze nomenclature used to describe the plans and making it more difficult for consumers to compare their options. The proposal to re-tighten the range of permissible variation therefore should reduce consumer confusion during plan selection and support more informed decision-making.

In addition, we believe that the proposed de minimis ranges will promote the adequacy and affordability of coverage. The proposals generally curtail issuers’ power to lowball the AV standards and sell less generous plans. (For example, the proposal would prohibit the sale of a 66 percent AV silver plan that is ostensibly supposed to provide an AV of 70 percent.) These limits will encourage the sale of relatively more protective coverage options. At the same time, the proposal to set an AV floor of 70 percent for individual market silver QHPs will both ensure a baseline level of generosity for these plans and result in lower after-subsidy premiums for many enrollees. We encourage the Department to finalize these changes as proposed.

Standardized Options for Marketplace Coverage and Meaningful Difference

Standardized health plan designs offer numerous advantages to patients and consumers. Requiring plans to adhere to uniform cost-sharing parameters promotes informed decision-making: the shared standards reduce consumer confusion and make it easier to draw meaningful comparisons based on variables such as plans’ premiums and network composition and design. Standardized plans also can be a tool for improving coverage affordability. Given that high deductibles pose a substantial barrier to needed care for many consumers, standard plans should exempt certain services, such as primary and mental health care, from the deductible. Plan designs should also favor copay structures instead of coinsurance, which both promotes affordability and makes it easier for consumers to understand their benefits. And, standard plans should contribute to larger policy efforts to reduce health disparities: plan standardization can be used to lower cost barriers to services and supplies that address health conditions that disproportionately affect people of color and others who historically have been underserved.

We support the proposal for standardized options to include copays instead of coinsurance in many categories. We urge the Department to expand the copays to more categories, including emergency room, inpatient hospital services, imaging, and labs. These are all services that will be used more by the people we represent. We are also concerned with the high deductibles proposed. By current Internal Revenue Service definition, five of the eight plans proposed in both sets are high deductible health plans.¹¹ We are especially concerned with the \$9,100 deductible in the Bronze standardized option. According to research previously cited by CMS in other rulemaking, nearly 4 in 10 adults would have difficulty paying for an emergency expense costing \$400.¹² People in this circumstance are the most likely to choose a Bronze option based on premium cost. A \$9,100 deductible is financially unreachable for many, especially those who are low-income or have a chronic health condition.¹³ Recent media reports show individuals avoiding medically recommended emergency room visits because of fears of cost. The individuals in this case had a deductible \$1,100 less than the deductible proposed for a Bronze standardized option.¹⁴ We urge the Department to lower the deductible amounts in the standardized options.

We support the Department's proposal to develop standardized plan options on HealthCare.gov and strongly agree that issuers must be required to offer standardized plans as a condition of marketplace participation. We also recommend that standardized plans be required in all marketplaces, including the SBMs, where a state-designed standardized plan program does not exist.

To maximize the consumer benefits of plan standardization, we urge HHS to do as most states with standardized plan programs have done and regulate the number of non-standard plans that issuers can offer.¹⁵ As the proposed rule documents, the sheer number of plans marketed through the marketplaces has sharply increased in recent years, and consumers are sometimes, in effect, overwhelmed by subtly different plans that are difficult to distinguish between. This choice environment favors issuers, not consumers, and can lead to poor enrollment decisions or discourage enrollment altogether. To mitigate this problem, the Department should set limits on non-standard options and establish standards, more stringent than those discontinued by the last administration, requiring an issuer's marketplace plans to be meaningfully different from each other. To the same ends, we also encourage HHS to differentially display standardized options on HealthCare.gov — and, so long as non-standardized options remain unlimited, consider prioritizing display of standard options — and to resume enforcement of standardized options display requirements for direct enrollment entities.

¹¹ High Deductible Health Plan (HDHP). US Department of Health and Human Services. <https://www.healthcare.gov/glossary/high-deductible-health-plan/>

¹² Board of Governors of the Federal Reserve System, Report on the Economic Well-Being of U.S. Households in 2018 (May 2019), available at: <https://www.federalreserve.gov/publications/2019-economic-well-being-of-ushouseholds-in-2018-dealing-with-unexpected-expenses.htm>.

¹³ <https://news.usc.edu/140182/high-deductible-health-plans-raise-risk-of-financial-ruin-for-vulnerable-americans-study-finds/>

¹⁴ Farmer, Blake. Nashville Public Radio. November 19, 2021. <https://khn.org/news/article/bill-of-the-month-emergency-room-surprise-billing-6500-dollars-for-six-stitches/>

¹⁵ Giovannelli J, Schwab R, Lucia K. State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>. Published July 28, 2021.

Network Adequacy

Federal law requires all marketplace health plans to maintain an adequate network of providers and an accurate and up-to-date online provider directory. These protections are designed to ensure that marketplace enrollees have timely, meaningful access to the care and services they need, as well as accurate information sufficient to enable them to understand plans' networks and identify the plans and providers most likely to meet their needs. They are vital to the patients and consumers we represent.

We were deeply disappointed by the prior administration's decision to eliminate federal network adequacy standards for plans offered through the FFM and to abandon federal oversight of marketplace plan networks. It is critical to restore and strengthen these protections and we strongly support the Department's proposals for doing so in the upcoming plan year and beyond.

For the federal statutory assurance of network adequacy to be meaningful, federal regulators must independently assess plans' networks and be proactive in oversight. We are therefore heartened that HHS intends to review for network adequacy during the annual certification process, i.e., before the plans may be sold, and to require issuers to submit data, and not mere attestations, to demonstrate compliance with consumer safeguards. We urge the Department to systematically test these submissions and to require issuers to provide additional information — such as data showing out-of-network claims submitted (as opposed merely to such claims denied) and the types of providers and services involved — to enhance regulators' understanding of how consumers are experiencing QHP networks in practice.

We are very supportive of the Department's proposal to establish a robust set of quantitative standards for assessing network sufficiency. These standards will provide needed clarity for stakeholders and the public and promote uniform, fair application of the federal network adequacy protection across insurers. As you know, HHS requires Medicare Advantage plans to satisfy concrete, numeric measures of network adequacy, and most states have adopted at least one quantitative standard for plan networks in the individual market. We are highly confident that any burden experienced by stakeholders in adapting to such standards in the marketplace context is far outweighed by the benefit to consumers of consistent and credible oversight of their plans' networks.

We appreciate that the quantitative standards proposed by HHS includes time and distance requirements as well as limits on the number of days enrollees may be required to wait for a provider appointment. With respect to the appointment wait time standards, we request that the Department conduct direct tests of compliance during the plan year. We believe that taking affirmative steps to monitor QHP networks is more likely to reveal problems and facilitate timely remediation than is a reactive approach focused only on complaint reporting. We also encourage CMS to consider strengthening the proposed network adequacy standards by including standards that ensure that a network incorporates a sufficient number of providers that are accepting **new patients** throughout the year.

We are pleased that the proposed rule seeks to clarify and strengthen additional aspects of federal network adequacy review. We support the proposal to reinvigorate standards intended to ensure consumers have sufficient in-network access to essential community providers (ECPs). We also agree with HHS that plans with tiered networks must satisfy network adequacy standards, including standards applicable to ECPs, at the lowest cost-sharing tier. It would frustrate the purpose of these federal protections if plans were permitted to condition adequate provider access on enrollees' willingness and ability to pay higher out-of-pocket costs.

Furthermore, our organizations appreciate that the Department plans to implement a pilot program designed to measure the relative breadth of QHP networks and display this information on HealthCare.gov. We support efforts to help consumers better understand and compare the composition and relative size of plans' networks. We urge the Department to explain clearly for consumers the methodology for the network breadth label -- what the label is (an indicator of relative network breadth), what it is not (a judgment regarding the absolute size of the network, or its suitability) -- and make provision for updating these labels should the relative size of a QHP's network change mid-year.

In addition, we support the Department's clarification that telehealth services may not be counted in place of in-person service access for the purpose of satisfying network adequacy standards. Telehealth should supplement, not supplant, provider networks. The inclusion of telehealth can bring substantial benefit to patients, and we encourage CMS to include telehealth as an aspect of network adequacy in the future. The decision to use telehealth should be made by the provider and patient based on preference and clinical appropriateness, and plans should not use cost-sharing to steer patients into or out of telehealth. Further, QHPs must ensure that patient referrals to other providers, including specialists, are within network when made by a telehealth provider or through a telehealth visit. These telehealth capabilities should be readily accessible in the provider directories.¹⁶

As you consider how to improve network oversight further, we urge the Department to scrutinize QHP networks' ability to provide culturally- and linguistically-competent care. This should include, among other things, a rigorous assessment of whether a network includes sufficient providers with appropriate language proficiencies, and/or provides sufficient access to appropriate language services, to ensure individuals with limited English proficiency can obtain timely care in their preferred language. It also means networks must ensure access to culturally appropriate care that reflects the diversity of enrollees' backgrounds and is attuned to traditionally underserved communities, including people of color, immigrants, and LGBTQI+ individuals. Further, to enable consumers to identify the plans and providers likely to meet their needs, QHPs must be required to indicate in their provider directories the languages, other than English, which are spoken by a provider and/or their staff.

Finally, our organizations share the Department's concern about the lack of consistency in network adequacy standards across states. While, as noted above, states have gravitated, slowly, towards the use of quantitative standards, regulatory approaches remain highly fragmented. This is despite the fact that network regulation and narrow networks pose common challenges across jurisdictions and that the National Association of Insurance Commissioners (NAIC) endorsed a common regulatory approach, more than six years ago, by adopting a network adequacy model act. More fundamentally, the disparity in state approaches to network adequacy in the marketplaces is concerning because the protection itself is federal. We believe strongly that a marketplace consumer's ability to access an adequate network of providers should not depend on what state she lives in. We therefore support the adoption of federal baseline quantitative standards for all marketplaces, federal and state-run alike. Just as with many other ACA consumer protections, states could retain flexibility to apply and enforce standards that are more stringent than the federal minimum. But marketplace issuers in all states should be accountable for ensuring their enrollees have an adequate network as promised by federal law.

¹⁶ <https://www.cff.org/sites/default/files/2021-10/Coalition-Principles-on-Telehealth-Policies.pdf>

Quality Standards: Quality Improvement Strategy

An issuer that participates in an ACA marketplace for two or more consecutive years must implement and report on a quality improvement strategy (QIS) that provides increased reimbursement or other incentives for activities designed to improve health care for enrollees. The QIS must relate to a health care topic area identified in the ACA, one of which is reducing health and health care disparities. The proposed rule would require issuers to address health and health care disparities as a specific topic area within their QIS, in addition to at least one of the other topic areas described in the ACA.

As the proposed rule details, health disparities persist in the United States across a range of dimensions. We applaud the administration's commitment to reducing these disparities and to achieving equity in health care outcomes for marketplace enrollees, specifically. We believe the proposed change to QHP quality standards advances these goals and we strongly support it.

Medical Loss Ratio: Expenses for Activities that Improve Health Care Quality

Issuers must spend a specified percentage of their premium revenue on claims and quality improvement activities (QIAs) and provide a rebate to enrollees if such spending falls below the threshold. HHS has observed significant discrepancies in the types of expenses that insurers classify as relating to QIAs. This creates an unequal playing field among insurers and deprives consumers of value for their premium dollars. The Department proposes to clarify and make more stringent the definition of QIA expenses to reduce the abuses it has observed, and we support this effort.

We also encourage HHS to reconsider the standards a wellness program must meet to qualify as a QIA. The proposed rule expresses concern that some issuers incorrectly classify profits they make for providing wellness incentives to enrollees. We are further concerned that issuers may classify as QIAs many programs and activities that do not in fact promote or increase wellness and health. The track record of wellness programs in improving wellness is decidedly mixed and such programs may actually pose risks to people with lower incomes or who are in poor health.¹⁷ We urge HHS to take steps to prevent issuers from benefiting under MLR rules by using purported wellness activities that lack an evidentiary basis.

Health Equity

In July, we submitted comments in response to the Office of Management and Budget Request for Information regarding equity and underserved communities.¹⁸ We support HHS' efforts to collect and disaggregate data to understand how policies impact communities differently and create inequalities in coverage and care.

HHS needs to make clear that the goal of health equity requires action beyond providing equal health benefits to all enrollees. Requiring QHP issuers obtain the National Committee for Quality Assurance (NCQA) Health Equity Accreditation is a minimum step QHP issuers should be required to take on collection and use of demographic data, ensuring access to people with limited English proficiency, and making progress towards cultural responsiveness and reducing health care disparities. But more steps are needed to improve demographic data collection. HealthCare.gov should work to improve the response rate to race and ethnicity demographic questions by testing different ways of presenting the

¹⁷ See, e.g., Davenport K. Changes in Wellness Programs Suggest Employers Are Rethinking Health Promotion. Georgetown University Center on Health Insurance Reforms. <http://chirblog.org/changes-wellness-programs-suggest-employers-rethinking-health-promotion/>. Published January 12, 2022.

¹⁸ <https://www.cff.org/sites/default/files/2021-10/PPC-Comments-to-OMB-Responding-to-Health-Equity-RFI.pdf>

question and providing a script to navigators, assistors, and brokers about the importance of answering the question, similar to recent reforms in New York.¹⁹ HHS should also have QHP issuers reach out to enrollees after enrollment to try and fill in missing demographic data, similar to the District of Columbia.²⁰ Data collected at enrollment should also include gender identity, rather than sex, and the primary language of each enrollee.

In addition to improving data collection, the data must be analyzed to identify inequities. This includes requiring QHP issuers analyze networks to determine if there are disparities in provider access based on race and ethnicity of enrollees. The Department should look to efforts in California and the District of Columbia to have QHP issuers analyze data to identify inequities based on race and ethnicity. In determining what health conditions HHS should analyze to identify gaps in health care, it is important to consider both conditions that affect large populations, such as diabetes, but also rarer conditions that disproportionately affect people of color, such as sickle cell disease. The Department should also look at access to services for the LBGTQI+ community, including services such as gender affirming care and access to PrEP. Identifying gaps and inequities will help HHS identify next steps to improve health equity. In the meantime, we commend HHS for thinking about ways QHP issuers can work to improve social determinants of health and urge the Department to provide flexibility to state-based marketplaces working towards improving health equity.

Thank you again for the opportunity to comment on the Notice of Benefits and Payment Parameters for 2023 Proposed Rule. Please contact Theresa Alban of the Cystic Fibrosis Foundation at talban@cff.org if you have any questions.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Cancer Support Community
CancerCare
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Eczema Association

¹⁹ Colin Planalp, [New York State of Health Pilot Yields Increased Race and Ethnicity Question Response Rates](#), State Health and Value Strategies, Princeton University, September 9, 2021.

²⁰ DC Health Benefit Exchange Authority, [Resolution to adopt the consensus recommendations of the Social Justice and Health Disparities Working Group to advance equity and reduce health disparities in health insurance coverage for communities of color](#), July 14, 2021.

National Hemophilia Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
United Way Worldwide