



Charles N. Kahn III
President and CEO

December 11, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: DRAFT 20189 Letter to Issuers in the Federally-facilitated Exchanges

Dear Administrator Verma,

The Federation of American Hospitals (FAH) appreciates the opportunity to comment on the *DRAFT 2019 Letter to Issuers in the Federally-facilitated Exchanges* (2019 Issuers Letter). The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members are diverse, including teaching and non-teaching, short-stay, rehabilitation, long-term acute care, psychiatric, and cancer hospitals in urban and rural America, and they provide a wide range of acute, post-acute, and ambulatory services.

Chapter 2: Qualified Health Plan and Stand-Alone Dental Plan Certification Standards

Section 3. Network Adequacy

i. Network Adequacy Standard and Certification Review

In its 2018 Market Stabilization rule,¹ CMS finalized its proposed change to rely on states for Qualified Health Plan (QHP) certification related to network adequacy. We opposed

¹ Department of Health and Human Services: Patient Protection and Affordable Care Act; Market Stabilization Final Rule, April 18, 2017, 82 *Federal Register* 18346, <https://www.gpo.gov/fdsys/pkg/FR-2017-04-18/pdf/2017-07712.pdf>.

that change because we support a federal floor against which network adequacy can be assessed. In the Department of Health and Human Services' (HHS) Notice of Benefit and Payment Parameters for 2019 Proposed Rule (Proposed Rule), and which are reiterated in the 2019 Issuers Letter, CMS proposes changes to the Affordable Care Act's (ACA) network adequacy requirements that would further reduce the possibility of achieving a meaningful set of minimum federal consumer protection standards for coverage sold through the Exchanges.

Under the policy, CMS proposes to continue its 2018 policy to defer to the states' reviews to assess issuer network adequacy. In states that do not have the authority and means to conduct sufficient network adequacy reviews, CMS would rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity such as the National Committee for Quality Assurance. Unaccredited issuers would be required to submit an access plan to the state as part of the QHP application, demonstrating that the issuer has standards and procedures in place to maintain an adequate network consistent with the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act. This Model Act, if enacted into law by a state, establishes a floor of network adequacy standards, but, in itself, is insufficient to ensure that consumers have access to needed providers. Additionally, most states today have not enacted the Model Act's network adequacy standards nor have insurance regulators in most states incorporated the Model Act network adequacy standards into their regulatory process.

The FAH is very concerned about relying on the states to certify that issuers have adequate provider networks in the absence of robust federal criteria to assess an adequate provider network. The proposed policy would reverse rather than bolster consumer safety safeguards. As provider networks continue to narrow in ways not always transparent to consumers, we believe that consumers need to be assured of meaningful access to health care. An accessible range of hospitals and primary and specialty care physicians helps ensure such meaningful access to care. It is important to ensure an enrollee's ability to have a meaningful choice of providers and see a provider in a timely manner and at a location reasonably convenient to the enrollee. To that end, the FAH has long recommended and again urges that CMS adopt and adapt, to the meet the needs of the broader population served by QHPs, the Medicare Advantage network adequacy standards for the Exchanges. This would include, in addition to time and distance standards, requirements relating to the minimum number of providers that must be included in a network. We believe that by fully adopting the Medicare Advantage construct, Exchange consumers will benefit from more robust provider networks.

If CMS nevertheless moves forward in finalizing its proposal to defer to state review of network adequacy, we urge the agency to actively monitor states to ensure that they have the tools and resources to engage in meaningful review of network adequacy and that states in fact exercise their responsibility to conduct network adequacy reviews. Third-party accreditation and the NAIC Model Act standards alone are, in our view, insufficient safeguards to ensure that issuer networks are sufficiently populated and accessible to meet the needs of enrollees, especially those requiring a range of specialty providers or those who live in rural and medically underserved areas. This is why we also urge CMS to engage in oversight of accredited and unaccredited issuers to ensure that they, too, meet meaningful and transparent network adequacy standards.

Finally, we urge CMS to ensure the transparency of plan provider networks to consumers throughout the plan year so as to facilitate timely, accurate, and easily accessible information on in-network providers when in active need of medical care. Assurances on these fronts is necessary for building and maintaining robust provider networks that ensure the healthy functioning of the Exchanges, as well as the individual and small group markets more generally, and consumer access to strong provider networks of hospitals, primary and specialty care physicians, and other providers.

ii. Provider Transitions and Out-of-Network Cost Sharing for In-Network Settings

Enrollees Should be Timely Notified of Discontinued Providers

The FAH continues its support for CMS’s requirement that QHPs in all federally facilitated Exchanges (FFE) notify enrollees about a discontinuation in their network coverage of a contracted provider. We agree with CMS that it is important for enrollees to be notified of changes to the network on a timely basis. Consumers need accurate information about which providers are in-network to ensure that they can optimize their health insurance coverage and make informed and cost-effective choices.

QHPs in an FFE are required to make a good faith effort to provide written notice of a discontinued provider 30 days prior to the effective date of the change, or otherwise as soon as practicable, to all enrollees who are patients seen on a “regular basis” by the provider or who receive primary care from the provider whose contract is being discontinued. We believe that the requirement to notify all enrollees who are patients seen on a “regular basis” should be further defined. Specifically, we believe CMS should define “regular basis” as 12 months so that if an enrollee has seen a provider during the last 12 months, the enrollee would be notified if her provider is discontinued from the network. Adequate notification requirements are an important component of ensuring that consumers have a meaningful understanding of the networks they are selecting, and the availability of hospitals, physicians, and other providers in these networks. Enrollees who have seen a provider during the previous 12 months should be promptly informed when that provider is discontinued from the network so that they can make informed provider choices going forward.

We believe that enrollee notification requirements should provide sufficient time for enrollees to be advised of a discontinued provider, and, when warranted, a special enrollment period for affected consumers to allow them to select a different QHP network. When enrollees learn of a discontinued provider, they need adequate time to become informed about the various QHP networks and other available providers, and we believe the current 30-day timeframe should be expanded to 90 days. This would allow enrollees time to obtain the information needed to make smart choices.

Further, additional safeguards are necessary to ensure that enrollees have a meaningful understanding of the providers in their network at the time they select a QHP and throughout the year. It is important that the Exchanges safeguard against significant mid-year provider terminations that impact enrollee access to providers. As evidenced by previous experiences in

Medicare Advantage, mid-year provider terminations can substantially alter a plan network, causing abrupt changes to consumers' choice of providers, and interfering with continuity of care. It is therefore important that HHS establish rules for the Exchanges that encompass the following:

- Standards regarding what constitutes a “significant” provider termination;
- Rules requiring QHP notification of, and approval by, regional account managers and/or other appropriate federal personnel if significant provider terminations may be necessary; and,
- Blackout periods (such as during open enrollment) during which provider terminations are prohibited.

Enhancing consumer safeguards in this manner will work in concert with enhanced network adequacy requirements and oversight functions to ensure consumers gain and maintain access to robust provider networks.

Enrollees Should Receive Transitional Care When a Provider is Discontinued

When a provider is terminated without cause, QHPs are required to allow an enrollee in active treatment to continue treatment until it is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. The FAH strongly supports the requirement that QHPs offer such transitional assistance, which is critical to ensure continuity of care. Indeed, we urge CMS to go further, and apply this transitional care requirement regardless of whether a provider termination is with or without cause, or a provider leaves the network because the provider's contract is non-renewed, unless a patient safety concern can be established. Patients should be permitted to continue treatment when a provider is discontinued from the network regardless of why the provider is discontinued. Also, the FAH urges CMS to allow petitions for extended transitional relief should an additional transitional period be necessary.

Out-of-Network Cost Sharing for In-Network Settings

QHPs are required to count towards an enrollee's annual cost-share limit the cost-share associated with an essential health benefit provided by an out-of-network provider in an in-network facility, such as a hospital. However, this requirement does not apply if the QHP provides written notice to the enrollee that the provider might be out-of-network, and that the enrollee could be subject to additional cost-share that may not count toward the network annual limit on cost sharing. The notice must be provided by the longer of: (i) when the QHP would typically respond to a prior authorization request timely submitted; or, (ii) 48 hours before providing the benefit.

As the FAH has previously commented, we appreciate CMS's attention to this issue, often referred to as “surprise billing,” and the intent to protect consumers, but we believe the protections it proposes fall short of the mark. It is reasonable to assume that QHPs would routinely issue the required form letter. As a result, the consumer will remain exposed to the additional cost-share, while the plan keeps the consumer that much further away from reaching

the annual cost-share limit (the point at which the plan becomes fully responsible for the cost of care).

A better solution, which the FAH recommends that CMS adopt, is the “surprise billing” policy adopted by the NAIC. Under the NAIC Model Act, which addresses network adequacy more broadly, if a patient receives emergency treatment from an out-of-network provider (like an anesthesiologist, pathologist or radiologist) at an in-network facility, the patient would only be obligated to pay as if the provider was, in fact, in-network. If the billed amount from the out-of-network provider is at least \$500 more than the allowed amount under the patient’s plan, the Model Act offers a mediation process between the out-of-network physician and the insurance company when they cannot agree on a payment amount – essentially holding the patient harmless.

Further, before any non-emergency treatment is scheduled, the Model Act would require the in-network hospital to provide to the patient a written notice stating, among other items, that the patient might be treated by a provider who the patient’s plan determines is out-of-network. The notice would include a range of what the charges could be for treatment by such out-of-network providers. The notice would also include a statement that patients can obtain from a list of in-network providers from their plan, and can request treatment from such providers.

We believe this policy will provide real and needed protection for patients by providing an important measure of transparency combined with reasonable protections of patients’ financial interests and ability to access care. In addition, the NAIC Model Act strikes the right balance between the roles and responsibilities of hospitals, providers, and plans in situations in which a patient seeks care at an in-network hospital, but is treated by a provider who is not covered by the patient’s plan. The Model Act’s structured mediation process provides an appropriate and accessible forum to resolve conflicts that may arise when the out-of-network provider providing services within an in-network hospital believes the payment from the patient’s plan is inadequate.

iii. Network Transparency

The FAH is pleased that CMS will continue to test patient use and experience with the network breadth information it is currently providing to consumers. We have, in many past comment letters, stressed the importance of robust provider networks in ensuring the healthy functioning of Exchanges and consumer access to strong provider networks of hospitals, primary and specialty care physicians, and other providers.

In continuing to supply such information to consumers, the FAH continues to support CMS ensuring that the network breadth of all plans is measured using a single, consistent set of measures and that integrated networks are not singled-out in a way that allows them to avoid the measurement applicable to all other plans.

Section 4. Essential Community Providers

The 2019 Issuers Letter relies on the methods from the 2018 Issuers Letter that CMS plans to use to evaluate issuers' compliance with the regulatory standards for inclusion of essential community providers (ECPs) in QHP provider networks. ECPs serve predominantly low-income and medically underserved individuals, so requiring sufficient inclusion of ECPs in QHP networks is critical to ensuring all enrollees have meaningful access to health care services.

The FAH further supports CMS continuing to rely on its 2017 policy regarding the methodology for counting ECPs. Under the 2017 approach, QHPs count multiple providers at a single location as a single ECP for purposes of determining the available ECPs in the QHP service area and satisfying the ECP participation standard.

The FAH recommends that CMS permanently retain this approach to counting ECP providers. QHPs should not be permitted to count multiple providers at a single location toward available ECPs in the QHP's service area to satisfy the ECP participation standard. Permitting such a threshold would diminish health care access points for individuals in low-income and underserved communities, and would further weaken network adequacy standards. It is critical that enrollees have access to a strong network of providers, spread widely across a service area, because this is an important component in ensuring that access, as envisioned by the ACA, is meaningful and available to enrollees.

Section 6. Patient Safety Standards for QHP Issuers

The FAH commends CMS for continuing in 2019 the patient safety standards that were finalized in the 2017 HHS Notice of Benefit and Payment Parameters Final Rule (2017 Payment Notice) regarding QHP contracts with network hospitals with more than 50 beds.

The FAH has expressed support for CMS's continued flexible approach to QHP contracting with hospitals. This encourages expansion of voluntary, provider-driven initiatives to improve the quality and safety of health care, which is a primary goal of the Patient Safety Act (PSA). It also allows hospitals to build upon the many significant advances in patient safety and quality improvement goals that have developed since enactment of the PSA in 2005.

We also appreciate CMS's flexibility regarding QHP collection of information from hospitals to demonstrate compliance with the patient safety and quality requirements. In the 2017 Payment Notice, CMS discussed its intention that QHPs and hospitals have flexibility in meeting the collection of information requirements, and that hospital attestation to meeting the patient safety and quality requirements is sufficient.

Further, the FAH appreciates CMS's flexibility in not requiring, at this time, the use of AHRQ Common Formats to report patient safety events. We urge CMS to continue this approach in the future since we believe there are better software programs for Patient Safety Organizations (PSOs) and that a mandate to use AHRQ Common Formats would discourage private sector innovation and investment in the creation of new PSOs and could possibly cause current PSOs to consider delisting. Further, it would be costly and burdensome to convert to the

Common Formats, which is less precise than the level of specificity of event types and the number of fields allowing discrete data capture included in health software currently on the market. PSOs and their participants should be permitted to choose whether they will use AHRQ Common Formats or their own comparison metrics, as long as those metrics meet the requirements of the PSO.

Section 9. Review of Rates

The FAH has supported the ACA's rate review requirements and its implementing regulations because they provide an important layer of transparency and scrutiny to annual rate filings by insurers. Before the ACA, many states did little in the way of rate review, often simply approving whatever rates insurers filed with state insurance departments. As a result, large annual premium increases were common, even when underlying cost trends did not justify them.

The ACA's rate review provisions have helped to ensure that, in any state, large proposed rate increases for individual and small group insurance plans are evaluated by insurance regulators (or in the case of a state without effective rate review, by CMS) to determine whether those increases are based on reasonable cost assumptions and solid actuarial evidence and do not discriminate between insured individuals within similar risk categories. The ACA requires insurance companies to provide readily accessible and understandable information to their customers about their reasons for significant rate increases, as well as to publicly justify and post on their websites any unreasonable rate increases. CMS posts on a website state review results, and CMS and the states use the rate review information to assess QHP certification and compliance with the ACA's single risk pool requirement. Together, these steps are designed to provide the kind of transparency and scrutiny that helps to moderate increases in premiums.

We recognize that average individual and small group insurance rate requests have risen significantly in the past few years. Some of the steep increases were justified on the basis of high claims experience and underlying cost trends. Some amount of those increases, however, has been driven by insurer uncertainty over the ACA's future including its individual mandate, federal premium and cost-sharing subsidies, market reforms, and federal support for Exchange and enrollment activities. To ensure the integrity of the rates and the sustainability of the individual and small group markets, continuation of a robust rate review process, with review to ensure that proposed rates are actuarially sound and reasonable, needs to be assured.

The FAH thus opposes CMS's proposed change to the current effective rate review requirement that review be triggered if an insurer's proposed rate increase is 10 percent or more for the coming plan year. Under the proposal, the threshold for rate review would be raised to 15 percent. In addition, only those insurers with 15 percent or higher rate increases would be required to submit a *Consumer Justification Narrative* for those rate filings whereas, under existing rules, insurers with rate increases of 10 percent or more are required to do so. This proposed change would dilute the moderating pressures of rate review on the cost of individual and small group health insurance. Moreover, it would reduce public access to the type of pricing information and underlying trend, claims, and other data that enable experts as well as consumers to evaluate the value of the health insurance products being offered. We urge CMS not to move forward with this proposal.

Section 12. Supporting Informed Patient Choice/Meaningful Difference

Existing rules require issuers of QHPs to offer a product that is meaningfully different from its other QHP offerings. The standard was created to make it easier for consumers to choose among distinct plan options to more easily identify the one that is right for them. HHS notes in the Proposed Rule that because fewer insurers are participating in Exchanges, this standard is no longer necessary. While in some Exchanges we expect that to be true, many Exchanges remain with multiple choices of plans within several metal categories. By increasing the likelihood of multiple duplicative options in those markets, these proposed rules will make it more difficult for consumers to distinguish differences between plans, and likely increase confusion among consumers, undermining a consumer-friendly marketplace.

Section 13. Third Party Payment of Premiums and Cost Sharing

To achieve the goals of the ACA and success of the Exchanges, patients and the provider community should be able to work together to ensure that those who need and want coverage actually are able to obtain it. There is no reason to discriminate against low-income and financially needy individuals who cannot quite afford their premium payments.

The FAH supports CMS continuing to require QHPs to accept third party payment of premiums/cost sharing from authorized organizations. It is reasonable that assistance with premiums and cost-sharing be authorized, and equally reasonable that CMS could apply certain conditions, such as limiting the assistance to individuals not able to obtain other minimum essential coverage and requiring assistance until the end of the calendar year. This would help address any potential risk-pool impacts.

Section 14. Cost-Sharing Reduction Plan Variations

CMS proposes that the approach for providing cost-sharing reductions (CSRs) by issuers to consumers remains unchanged from the approach used in 2018. CMS confirms that consumers will have the opportunity to enroll in plans with CSRs available. CMS also confirms that CSR payments to issuers will not be made without a Congressional appropriation.

The FAH encourages CMS to reconsider its decision to not make CSR payments. Assuring the payment of CSRs is important for ensuring a robust and stable marketplace in 2019, while upholding current law and its intent to provide consumers, including those with lower incomes, with affordable and comprehensive health insurance.

Unfortunately, the lack of clarity around CSR payments is reflected in the premium increases for 2018 and will continue to have negative consequences for the marketplace in 2019. The continued uncertainty around these payments will inevitably lead to an increase in the number of individuals uninsured, an increase in uncompensated care costs, and an increase in federal outlays related to increasing premium costs.

Chapter 5: Qualified Health Plan Performance and Oversight

FFM Oversight of Agents and Brokers

Consumers approach their search for health insurance coverage from many angles, and as such it is important that they have wide and flexible access to assistance that meets their individual circumstances. Such assistance comes through many forms, including an easily navigable Healthcare.gov, informed certified application counselors, active Navigators, and the expertise of agents and brokers.

The FAH supports efforts to enhance the ability of each of these channels to help qualified individuals gain coverage. The FAH encourages CMS to monitor plan selection and enrollment patterns of individuals using these resources to ensure that this assistance is resulting in plan selections that meet consumer choice and need.

We appreciate your consideration of our recommendations. If you have any questions about our comments or need further information, please contact me or my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to be "Shirley M. [unclear]". The signature is written in a cursive style with a large initial 'S' and a long horizontal stroke at the end.