



Charles N. Kahn III
President & CEO

July 12, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Information; Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients

Dear Administrator Verma:

The Federation of American Hospitals (“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 include teaching and non-teaching, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services.

We appreciate the opportunity to express our views in response to the Centers for Medicare & Medicaid Services’ (“CMS”) Request for Information regarding how to improve and stabilize the individual health insurance marketplace. The ability to shop for and purchase coverage through the marketplace continues to be an important option for millions of Americans. It is imperative that the marketplace, in which they purchase coverage, is well-functioning and stable with options that provide necessary services at an affordable price. Improvements to the consumer experience, including enhanced affordability, start with the stability of the marketplace and patient-centered updates to the governing regulations. We believe there are a number of actions the Administration can take that will make important improvements to the marketplace.

Cost-Sharing Reduction (“CSR”) Payments

Assuring the payment of CSRs, at least through 2018, is the single most important action the Administration can take to ensure a robust and stable marketplace in 2018. There is clear evidence that the uncertainty around these payments is undermining the stability of the individual market for 2018 and as such will negatively impact millions of people.

Unfortunately, the lack of clarity around CSR payments has led a number of insurers to decline participation in the 2018 plan year. For those participating insurers, this uncertainty is reflected in the premium increases for 2018. 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. To avoid harming consumers, we encourage the Administration to make a strong statement assuring their payment for at least the 2018 plan year.

Guaranteed Availability of Coverage

In its *Patient Protection and Affordable Care Act; Marketplace Stabilization Proposed Rule*, CMS proposed that guaranteed availability requirements would allow an issuer to require a policyholder whose coverage is terminated for non-payment of premium in the individual or group market to pay all past due premiums owed to that issuer during the previous 12 months before reenrolling in coverage under the same or different product from the same issuer.

In comments regarding the proposal, the FAH urged CMS to ensure that issuers be required to inform enrollees whether an issuer has chosen to adopt the premium payment policy. We made this recommendation as we believe transparency is imperative so that enrollees can make the most optimal and well-informed choices tailored to their individual medical needs. The ability and information necessary to make smart choices is necessary to maximize meaningful health care coverage.

We also recommended that issuers be required to notify hospitals and other providers regarding an enrollee’s coverage status at the earliest opportunity. This notice is critical so that hospitals and other providers are not unfairly burdened in attempting to determine coverage status and whether it is necessary to try to obtain direct payment from the patient.

Finally, we recommended CMS clarify that once an individual pays past due premiums, that individual is considered to have had insurance coverage during the previous months to which the past premiums apply. Issuers should be required to provide appropriate payment to hospitals and other providers for medical services furnished during those months.

We appreciate that the final rule clarified that issuers are required to pay all appropriate claims for services provided during any month of coverage for which past-due premiums are collected. We also appreciate CMS affirming that issuers must notify providers of an individual’s payment status as well as ensuring that proper notification is available to individuals regarding an issuer’s premium payment policy. We encourage CMS to monitor issuers’ adherence to this policy as it is important to both the patient and provider.

Outreach and Enrollment Efforts

An important function of a stable marketplace is a commitment to ensuring consumers understand the value of insurance, how to enroll, and associated deadlines, and how they can determine what type of coverage is right for them. Consumer engagement is a critical component of such outreach, and we encourage the Administration to commit the necessary and appropriate resources to the outreach efforts we know result in more people gaining insurance.

Through direct assistance, consumers will be better able to assess their health care needs; plan options, including affordability; and the requirements and timelines for gaining such coverage. A limited engagement strategy for the 2018 plan year likely will result in depressed enrollment and individuals who would otherwise have gained coverage becoming or remaining uninsured.

Network Adequacy Requirements

CMS requires a qualified health plan (“QHP”) issuer to maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to ensure that all services will be accessible without unreasonable delay. Since 2017, CMS has implemented time and distance standards similar to those applied to Medicare Advantage plans to ensure that adequate provider networks are available.

As finalized in the *Patient Protection and Affordable Care Act; Marketplace Stabilization Final Rule*, beginning with the 2018 plan year, rather than performing a time and distance evaluation, CMS will rely on state reviews for network adequacy in states in which a federally facilitated Exchange (“FFE”) is operating, provided the state has a sufficient network adequacy review process. CMS will defer to states’ reviews in those states with the authority that is at least equal to a “reasonable access standard” (as defined under current regulation) and means to assess issuer network adequacy, regardless of whether the Exchange is a state-based Exchange or FFE, and regardless of whether the state performs plan management functions. In states that do not have the authority and means to conduct sufficient network adequacy reviews, CMS will rely on an issuer’s accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited issuers would be required to submit an access plan as part of the QHP application.

In comments to the Marketplace Stabilization proposed rule, the FAH expressed our support for a federal floor against which network adequacy can be assessed. Consumers need to be assured of meaningful access to healthcare, and access to a broad range of hospitals and primary and specialty care physicians helps ensure such meaningful access to care. It is important that enrollees have a meaningful choice of providers and can see providers in a timely manner and at a reasonably convenient location. To that end, the FAH has long recommended that CMS adopt and adapt, to 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.

While we disagree with the policy CMS finalized in April to defer to states' review of network adequacy, we urge CMS to actively monitor to ensure that states have the tools and resources to engage in meaningful review of network adequacy, and that states in fact exercise their responsibility in conducting network adequacy reviews. We further urge CMS to engage in oversight of accredited and unaccredited issuers to ensure that they meet meaningful and transparent network adequacy standards. Finally, we urge CMS to ensure the transparency of provider networks to consumers making decisions about certain plans and throughout the plan year so that consumers are able to easily choose in-network providers when receiving medical care. Assurances on these fronts is necessary for building and maintaining robust provider networks that ensure the healthy functioning of Exchanges and consumer access to hospitals, primary and specialty care physicians, among other providers.

Timely Notification of Discontinued Providers

In the *2017 HHS Notice of Benefit and Payment Parameters for 2017 Final Rule*, CMS finalized a policy to require QHPs in all FFEs to notify enrollees about a discontinuation in their network coverage of a contracted provider. The FAH supports that policy as 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.

CMS's policy requires QHPs in an FFE 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. In its final rule, CMS declined to define "regular basis."

The FAH believes that the requirement to notify all enrollees who are patients seen on a "regular basis" should be further defined. Specifically, we urge CMS to 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. Patients 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.

Additionally, 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. When enrollees learn of a discontinued provider, they need adequate time to become informed about the various QHP networks and other available providers. We believe expanding the current 30-day timeframe to 90 days would allow enrollees time to obtain the information needed to make smart choices.

We believe that 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. In particular, 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 interfere 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 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.

Transitional Care When a Provider is Discontinued

As finalized in the *HHS Notice of Benefit and Payment Parameters for 2017 Final Rule*, when a provider is terminated without cause, CMS requires QHPs 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 requiring QHPs to offer such transitional assistance, which is critical for 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.

Third Party Payment of QHP Premiums

It is clear that any system developed to assist low-income people in attaining health insurance will require these individuals to receive assistance with premium and cost-sharing payments. Even with these subsidies, however, many still experience significant financial challenges. It stands to reason, therefore, that CMS policy should favor third parties who wish to provide financial assistance to those who most need it to help them purchase and maintain health care coverage. Specifically, patients and the provider community should be able to work together to ensure that those who need and want coverage actually receive it.

CMS should expand the number of entities that QHPs are required to accept third party payment (premiums/cost sharing) from to additional organizations that promote or serve healthcare in a community. It is reasonable that assistance with premiums and cost-sharing could come from many sources in the community, and 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, although we note that third party payments may help expand the size of the pool and better spread the risk. Further, risk-pool issues may not arise from third party payments because it is not possible to predict whether these third party payments will be made only for those needing more intensive medical services. It is just as likely that these payments would help those who are financially needy, yet relatively healthy, purchase needed health care insurance.

The FAH believes that, to the extent that there are providers that steer Medicare and/or Medicaid-eligible individuals to individual market plans, a practice that CMS should rightly address, this problem is isolated to a small segment of providers and is not widespread. In addressing any such problem, the FAH urges CMS to target interventions narrowly around the problem.

Timely Notification is Needed for Patients in Grace Period Due to Non-Payment of Premiums

Under current regulations, CMS has promulgated a policy that permits QHPs to terminate coverage after 30 days of non-payment of insurance premiums by individuals who qualify for advance payment of premium tax credits. Specifically, QHPs are required to only pay all appropriate claims for services provided during the first month of the grace period, and could suspend claims for services furnished during the second and third months. If a consumer does not pay his/her outstanding premiums by the end of the three-month grace period, the QHP may deny all pending claims for services rendered during the second and third months.

The FAH is opposed to this policy, which effectively allows QHPs to retroactively terminate coverage for the second two months of the grace period. This policy subjects enrollees to significant personal liability for services received during the second two months.

The policy also unfairly burdens providers who treat these patients because they will not get paid by the QHP for covered services and will have to wait to try to obtain direct payment from the patient. The reality is that it will be extremely difficult to collect payment from low-income patients who already are having trouble paying their QHP premiums.

Further, the policy is exacerbated by the fact that in our hospital members' experience, QHPs are not timely notifying hospitals that an enrollee (who receives advance premium tax credits) is in the 90-day grace period. We urge CMS to exercise oversight of QHPs in this regard, and, as CMS affirmed in the *Patient Protection and Affordable Care Act; Marketplace Stabilization Proposed Rule*, ensure that QHPs timely comply with notification requirements to hospitals that an enrollee is in the 90-day grace for non-payment of premiums. This timely information would assist hospitals in encouraging enrollment, helping enrollees avoid unanticipated and significant personal liability for services received, and providing these

enrollees with information about potential charitable organizations that provide premium and cost-sharing assistance.

The FAH appreciates the opportunity to comment on the Request for Information. If you have any questions about our comments or need further information, please contact my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. ...". The signature is fluid and cursive, with a large initial "A" and "M".