



Charles N. Kahn III
President and CEO

January 30, 2023

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

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024 [CMS-9899-P]

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. The FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule on the *HHS Notice of Benefit and Payment Parameters for 2024* (Proposed Rule) published in the Federal Register (87 Fed. Reg. 78,206) on December 21, 2022.

Proposals that Promote Enrollment, Continuous Coverage, and Equity

The FAH strongly supports policies that further the *Patient Protection and Affordable Care Act's* (ACA's) goal of providing quality, affordable coverage and care to consumers, including those in the Proposed Rule that focus on helping consumers access and maintain coverage and promoting health equity. For example, the FAH encourages HHS to finalize the following proposals that would promote enrollment and continuous coverage:

- Failure to File and Reconcile Process (Part III.B.4.a, 45 C.F.R. § 155.305(f)(4))**
 The FAH supports the proposed revisions to § 155.305(f)(4), which would preserve consumer access to advance payments of the premium tax credit (APTC) unless the consumer has failed to file and reconcile their past APTC for two consecutive years. This policy would reduce the inappropriate gaps in coverage created under the current policy, provide greater opportunity for consumer education on the requirements and process, and make the process less punitive while still protecting consumers from accruing large tax liabilities over multiple years.
- Verification Process Related to Eligibility for Insurance Affordability Programs – Income Inconsistencies (Part III.B.5.a, 45 C.F.R. §§ 155.315, 155.320)**
 The FAH strongly supports the proposals to: (1) accept an applicant’s or an enrollee’s attestation of projected annual household income when IRS tax return data is requested but is not available; and (2) provide an automatic 60-day extension to provide documentation to verify household income. These proposals are critical for helping to ensure continuous coverage, promoting health equity, and strengthening the risk pool on the ACA Exchanges.
- Special Enrollment Periods (Part III.B.7, 45 C.F.R. § 155.420)**
 Special enrollment periods (SEPs) are important to ensuring that consumers have appropriate access to coverage when circumstances change mid-year, and the FAH supports the proposed changes to § 155.420 that make technical corrections, close temporal gaps following the mid-month loss of coverage, align the SEP following loss of Medicaid or CHIP coverage with the reconsideration period available under 42 C.F.R. § 435.916(a), and refocus the plan display error SEP on the affected enrollment. SEPs will be of particular importance due to the anticipated loss of coverage due to Medicaid/CHIP unwinding over the coming years, and the FAH appreciates CMS’s effort to identify opportunities to better support impacted consumers through earlier effective dates for certain mid-month losses of coverage and a longer SEP period following the loss of Medicaid or CHIP coverage.
- Termination of Exchange Enrollment or Coverage (Part III.B.8, 45 C.F.R. § 155.430)**
 The proposed addition of § 155.430(b)(3) would appropriately codify CMS’s existing policy prohibiting QHP issuers participating in an Exchange on the federal platform from terminating coverage of dependent children before the end of the coverage year once the child has turned 26 (or the maximum age under State law). The proposed change provides needed clarity to both enrollees and QHP issuers and appropriately continues the existing policy that avoids disruptive mid-year terminations and supports access to care for dependent children.
- Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (Part III.B.2, 45 C.F.R. §§ 155.210, 155.215, and 155.225)**
 Robust outreach and enrollment efforts is important to realizing the coverage goals of the Exchanges and in-person enrollment assistance is an important aspect of that effort, especially as Medicaid and CHIP unwinding increase consumer reliance on the

Exchanges for coverage in the coming years. To that end, the FAH supports CMS's proposal to reverse the prohibition on door-to-door and other unsolicited means of direct contact to provide enrollment assistance.

- **Annual Eligibility Redetermination (Part III.B.6, 45 C.F.R. § 155.335)**

The FAH also supports CMS's proposal to allow Exchanges to apply re-enrollment hierarchies that appropriately prioritize access to income-based cost-sharing reductions (CSRs) for eligible consumers. The FAH believes that placing these silver-level plans higher up on the re-enrollment hierarchy would promote the transition of CSR-eligible consumers to affordable plans with cost sharing benefits that better support their access to needed care.

Along similar lines, **the FAH supports the establishment of a timeliness standard for notices of payment delinquency (Part III.C.9.a, 45 C.F.R. § 156.270)**. The FAH agrees with CMS's commitment to improving basic standards of communication between QHP issuers and enrollees regarding premium payment status as a critical strategy to support access to stable coverage among consumers. Prompt notice maximizes the enrollee's opportunity to bring his or her premium payments current and maintain coverage, and the FAH therefore supports a deadline for notice that is no more than one week following delinquency. To this end, the FAH urges HHS to finalize the proposed revision to § 156.270(f) with a modification to specify a deadline of no more than one week for delivery of the notice of delinquency.

Non-Standardized Plan Option Limits (Part III.C.4, 45 C.F.R. § 156.202)

The FAH supports Exchange policies that are intended to ensure consumers have a robust choice of plans that offer a variety of benefits while at the same time simplifying choices for beneficiaries so that comparing options is feasible. Policies that artificially limit the plan options available to consumers through the Exchanges, however, are not consistent with the robust consumer choice that is indicative of a vibrant market and are not necessary to enable meaningful plan comparisons by consumers. Therefore, the FAH does not support CMS's proposal to limit the number of non-standardized plan options that a QHP can offer. Rather, the FAH urges CMS to evaluate the success of its recent enhancements to the choice architecture on HealthCare.gov to determine whether additional changes are necessary to support informed choice among consumers. While we agree that consumers can be overwhelmed by choices when a plethora of plans are offered, we also believe that consumers want a choice of providers when it comes to choosing a health plan and can readily distinguish options based on the hospitals and physicians they know and trust and that they will want available to them when needed.

We encourage further analysis of the proposed limit on plan options to consider whether a broad range of providers is not excluded or limited by this proposed approach, particularly providers that are frequently sought out by smaller segments of the population, for example, patients in an underserved community. We also highlight a key difference in using this approach to narrow the selection of Medicare Advantage (MA) plans versus for QHPs in the Exchanges. MA is an optional program for Medicare-eligible consumers and if their overall selection of plans does not offer the hospitals and physicians they prefer, those consumers can choose the Medicare fee-for-service (FFS) alternative. However, for Exchange consumers, particularly the majority seeking silver plans, there is no similar FFS alternative to provide a fall back option.

In the alternative to limits on non-standardized options, CMS proposes to adopt a new, more stringent meaningful difference standard for plan offerings. The FAH is deeply concerned that the proposed meaningful difference standard does not account for meaningful differences in network configurations between plans. Beyond product network type (e.g., HMO vs. PPO), consumers differentiate between plan options based on the composition of their provider networks (e.g., broad network vs. narrow network). The meaningful difference standard proposed, however, limits meaningful differences between plans to differences in deductible amounts for plans that share the same issuer ID, county, metal level, product network type, and deductible integration type. This approach would significantly limit consumer choice and harm competition based on provider network composition. To the extent that CMS considers adopting a meaningful difference standard, the FAH strongly urges CMS to recognize that differences in provider network composition are in fact meaningful and to ensure that issuers retain the flexibility to offer both narrow and broad network versions of otherwise similar plans.

Plans that Do Not Use a Provider Network: Network Adequacy (Part III.C.7, 45 C.F.R. §§ 156.230)

The FAH supports CMS's proposal to extend network adequacy requirements more broadly and consistently to QHP issuers. We encourage CMS to pursue audits of network adequacy that not only identify contracted providers in provider directories, including for inpatient rehabilitation and other post-acute care services, but also measure consumers' ability to access all contracted providers under transparent rules with minimal burdens.

Essential Community Providers (Part III.C.8, 45 C.F.R. §§ 156.235)

The FAH supports strengthening essential community provider (ECP) standards to expand access, particularly for low-income and medically underserved consumers, including the proposal to add ECP categories for mental health facilities and substance use disorder treatment centers.

Thank you for the opportunity to comment on the Proposed Rule. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,

