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January 27, 2022

Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 212441

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

Dear Administrator Brooks-LaSure:

The National Health Council (NHC) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS') proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2023."

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable health care. Made up of more than 140 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic, and payer organizations.

The NHC applauds CMS' commitment to advance policies that "ensure the Marketplaces are a model for accessible,

affordable, inclusive coverage”¹ and advance health equity for consumers purchasing Marketplace coverage. We have, since enactment and implementation of the Affordable Care Act (ACA), advocated for policy refinements that promote marketplace stability and

- Provide consumers with a robust set of plans and actionable, quality information to enable them to choose the plan that most suits their needs;
- Ensure comprehensive coverage, including network adequacy;
- Advance health equity; and
- Facilitate marketplace stability.

We particularly appreciate that many of the policy refinements within the Proposed Rule consider the needs of individuals with chronic conditions and disabilities for whom meaningful and affordable health coverage is essential to ensuring access to the health care they need at a cost they can afford. Our specific comments are below.

I. Ensuring comprehensive coverage and network adequacy

Identifying and addressing discriminatory plan design

The NHC has, since implementation of the ACA, urged CMS to strengthen the nondiscrimination provisions of the ACA through meaningful guidance on the types of plan design components that prohibit discriminatory practices. We strongly support the steps CMS has taken in the Proposed Rule to increase clarity for issuers and other stakeholders that can ultimately improve the ability of marketplace plans to address the care needs of all Americans.

We fully support CMS’ proposal to ensure that benefit limitations and plan coverage requirements are grounded in clinical evidence rather than based solely (or primarily) on economic factors and agree that a nondiscriminatory benefit design is one that is “clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources.”² It will be important as CMS moves forward with this proposal, that evidence is defined in a way that protects access to needed services.

We recommend that CMS:

- Engage patient representatives, providers, specialty societies, and other stakeholders to identify additional credible, equitable, unbiased, evidence-based sources that should be considered;
- Include coverage and benefit implementation processes within its assessment of discriminatory plan design. Patient access constrictions are often related to

¹ Statement of CMS Administrator Chiquita Brooks-LaSure, December 28, 2021, [HHS to Make Coverage More Accessible and Affordable for Millions of Americans in 2023 | CMS](#)

² [Federal Register :: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023](#)

issuer policies that are not delineated in plan summary information, and can include utilization management strategies such as step therapy and overly burdensome prior authorization processes for entire classes of patients and/or treatments;

- Provide clear and direct guidance to plans about what constitutes discrimination, particularly practices that are not included in the list of examples in the proposed rule. Further detailed guidance is needed to help plans understand exactly what non-discrimination measures need to be put in place and avoid unnecessary restrictions due to lack of clarity; This would also give patients more clarity when identifying discriminatory practices; and
- Identify a mechanism through which patients can report real-world experiences of discriminatory plan design and/or coverage and benefits implementation.

The NHC similarly appreciates that CMS has provided examples of practices that would be presumptively discriminatory and urges you to seek input from the stakeholder community on additional practices that have had a discriminatory impact on patients. For individuals with chronic conditions and disabilities, prescription drug tiering is particularly problematic and potentially discriminatory. We agree that examination of plan design should include prescription drug tiers. Plans with nondiscriminatory designs are those that apply neutral principles, based on clinical evidence, consistently across types of drugs. We also agree that conditions for which all, or nearly all treatment options are assigned to tiers with high out-of-pocket costs exhibit a discriminatory design that must be cured. As CMS stated:

“Issuers should expect to cover and provide sufficient access to treatment recommendations that have the highest degree of clinical consensus based on available data, such as professional clinical practice guidelines. Placing all drugs for a high cost chronic condition on the highest formulary tier is a presumed discriminatory benefit design, even when those drugs are costly.”

This clarification, if implemented and enforced, represents a substantial step toward ensuring that the ACA fulfills its potential for individuals with chronic conditions and disabilities.

We also support CMS' proposal to monitor plan use of telehealth services, including plan designs offering lower out-of-pocket costs for telehealth services, to determine whether telehealth service implementation perpetuates and/or exacerbates health inequities. The NHC strongly supports telemedicine as an option when it is chosen by patients in consultation with their health care provider(s), while acknowledging that telemedicine is not a substitute for face-to-face visits for all patients.

Eliminating option for states to permit issuer substitution of benefits between EHB categories

The NHC supports CMS' reversal of the 2019 Payment Notice provision amending the ACA regulations to grant flexibility for states to permit issuer substitution of benefits

between EHB categories. We opposed this 2019 decision, as we believed that the policy change, if implemented by the states, would have potential harmful impacts on individuals with chronic conditions and disabilities. We applaud CMS for assessing the potential harms against the current and future utility of this flexibility with respect to states seeking to promote consumer choice and plan innovation with coverage and plan design options falling outside the EHB requirements. In particular, we appreciate that CMS has determined that the potential for harm to individuals living with chronic conditions and disabilities outweighs the regulatory provision's untapped flexibility.

Network adequacy standards

The NHC fully supports CMS' proposal to strengthen and clarify network adequacy standards. Network adequacy has presented a critical equity issue for marginalized populations and people with chronic conditions and disabilities who rely on Marketplace coverage. We appreciate that Department's proposal establishes 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 protection across insurers. Specifically, we applaud CMS for its proposals to:

- Expand the provider specialty list for time and distance standards;
- Include appointment wait time standards in evaluating network adequacy (though we note the current pandemic may be negatively impacting wait times);
- Annually review plans network adequacy submissions; and
- Require that providers included toward issuer satisfaction of network adequacy and essential community provider (ECP) standards must be contracted within the network tier with the lowest cost-sharing.

We also applaud CMS for its proposal to require issuers to submit information about whether providers offer telehealth services and its decision that, for network adequacy purposes, telemedicine visit availability is not a substitute for face-to-face provider access. The NHC recently conducted a series of listening sessions with patient organizations to learn more about experiences with telemedicine for patients with chronic diseases. We found that, while most patients enjoy the convenience of telemedicine, it does not work for everyone. Depending on how it is implemented, telemedicine has potential to either reduce *or* perpetuate health disparities. Patients, in consultation with their providers, are in the best position to determine whether a virtual, audio-only, or in-person visit is the right fit. We are encouraged that CMS' proposal strikes an appropriate balance so that patients are informed of telemedicine availability when shopping for a plan, but that telemedicine does not become a substitute for in-person care when not appropriate.

The NHC encourages CMS to continue its efforts to strengthen and clarify network adequacy standards and that it consider including standards that ensure that a network:

- Incorporates a sufficient number of providers that are accepting ***new patients*** throughout the year;

- Assure that adequacy standards consider the number of culturally and linguistically appropriate providers in network;
- Provides reasonable access to specialists and other providers who serve the needs of enrollees with rare, chronic, or complex medical conditions; and
- Includes an adequate number of in-network providers in various specialties corresponding to the categories of essential health benefits.

Essential Community Provider (ECP) threshold

The NHC applauds CMS' proposed increase in the ECP threshold from 20 to 35 percent of available ECPs in each plan's service area. ECPs can play a critical role in ensuring access to care for vulnerable populations. We agree that, given that 80 percent of 2021 medical FFM issuers were able to satisfy the 35 percent threshold, reliance on the write-in and justification processes for issuers unable to meet that threshold strikes a pragmatic balance.

In addition, and outside of the context of the NBPP, we encourage CMS to continue to strengthen the ECP system. Through the NHC's health equity work over the last year, it has become clear that we need to work together to assure that ECPs are sufficiently supported and resourced to play the important role that we are asking of them. If they are going to be a resource to meet network adequacy standards, plans and the government must work together to make sure they have what they need to do that work.

II. Plan choice and transparency

Issuer plan offerings

CMS proposes to require that issuers in the Federally Facilitated marketplaces (FFMs) and State-based Marketplaces on the Federal Platform (SBM-FPs) offer standardized plan options at each metal level, and throughout every service area in which they offer non-standardized options. In addition, CMS proposes to display the standardized options differentially on HealthCare.gov and enforce the differential display requirement for web brokers and qualified health plan (QHP) issuers utilizing a Classic or Enhanced Direct Enrollment pathway.

We support CMS' goals in proposing a requirement that issuers offering non-standardized plans also offer standardized options. If the proposal is implemented, particularly if it is paired with policies that reduce the number of non-standard options, we urge CMS to engage the patient community and monitor potential unintended consequences related to plan choice. CMS should monitor the breadth of plan offerings in a sufficient variety of geographic areas to ensure that the policy is improving consumer choice with respect to selecting a plan that suits the needs and goals of patients, particularly those with chronic conditions and disabilities.

As CMS moves forward in developing a methodology for designing standardized plans, we urge it to engage with stakeholders, including patients with chronic diseases and disabilities and payers, so that the benefits and costs associated with standardized plans meet patient needs without disrupting Marketplace competition and viability. This outreach and engagement should afford CMS the opportunity to develop a proposed

methodology in collaboration with stakeholders and offer the opportunity for public notice and comment on any resultant proposal.

We strongly support CMS' decision to include copays, instead of coinsurance, in the standardized plan designs for all drug tiers. Using copays instead of coinsurance fits with CMS' goal of increasing transparency to consumers and easing the plan choice process. When plans require coinsurance, shoppers have no meaningful way to predict what their actual cost sharing might be. People with chronic conditions and disabilities are the most likely to be on high-cost drugs and end up paying high amounts in coinsurance, which they may not be able to afford. Copays provide predictability and confidence when choosing a plan. However, overall copays and deductibles remain high. We urge CMS to consider lower deductibles and lower copay amounts when finalizing the standardized plan designs.

Preventing plan choice overload

The NHC supports policies that facilitate a robust, competitive Marketplace with sufficient plan choices to address the needs and goals of consumers seeking coverage. We also appreciate that CMS seeks to simplify the consumer experience in evaluating the coverage and costs associated with Marketplace plan options. The potential for plan choice overload is a function of both the number of offerings from which to choose and the ease with which actionable and understandable information on options can be gathered, sorted, compared, and assessed to facilitate a decision that matches the individual's needs, goals, and expectations. One way CMS can address concerns with plan choice overload by first working to enhance the breadth and presentation of information available throughout the shopping process. We urge CMS to engage patients and patient advocacy organizations as it continues efforts to improve the consumer experience in selecting a plan. Individuals seeking health care coverage need information that is consistent, concise, and enables apples-to-apples comparisons between plan options. Examples of actionable plan information that can enhance the decision process include:

- Information on non-standardized plans that clearly delineates the differences (benchmarked to the standardized plan) in premium, deductible, drug formulary, provider network, out-of-pocket costs, and covered benefits;
- Specific coverage details, such as limits for ancillary services;
- Tools that enable consumers to estimate total out-of-pocket costs associated with their anticipated health care needs; and
- Access to plan Summary of Benefits and Coverage (SBC) information early in the shopping process.

Addressing copay accumulators

We also urge CMS to re-examine its position on issuer policies (e.g., copayment accumulator programs for prescription drugs) that might impact out-of-pocket costs but are often not disclosed before plan enrollment. **The NHC has previously urged CMS to scale back its policy on copayment accumulators to prohibit plans from applying those policies to drugs without generic competition. We ask that the**

Agency again revisit the financial impact that this issuer cost-reduction strategy has on patients with chronic conditions and disabilities who require higher-cost treatments. In our previous comments, we also asked that even if CMS were to revert to the 2020 NBPP, which differentiated between products with and without generic competition, we would support additional safeguards such as differentiating between manufacturer and charitable assistance, ensuring it only applies when a generic is available and on a lower cost-sharing tier, and excluding therapeutic classes where there is high variability in patient response to different versions of brand and generic drugs.

In the interim, we ask that information presented to consumers as they shop for health coverage include whether and how the plan has implemented copayment accumulator program, so that patients have a clearer understanding of their cost-sharing burden over the course of the plan year.

III. Improving insurance coverage to advance health equity ***Prohibiting discrimination based on sexual orientation and gender identity***

The NHC fully supports CMS' proposal to explicitly prohibit marketplaces, issuers, agents, and brokers from discriminating against consumers based on sexual orientation and/or gender identity.³ Enforcing the anti-discrimination provisions of the Affordable Care Act (ACA) is critical to the well-being of all Americans, including those with serious, acute, chronic, or other pre-existing conditions in the LGBT+ community. The NHC applauds CMS for implementing policies that underscore the fundamental principle that everyone deserves access to health care services without fear of being treated differently because of who they are. We look forward to working with you to address other policies that have weakened the anti-discrimination protections within the ACA, including those associated with discriminatory plan designs outlined above.

Solicitation of comments on health equity

Over the last year, NHC has led an effort to solicit recommendations from the patient perspective about policy recommendations to address health equity in four key areas. These include access to coverage, access to care, equity in medical innovation, and social determinants of health. The specific recommendations of most relevance to the questions from CMS in this section are the policy recommendations on access to coverage⁴ and our response to the Request for Information from the newly formed Congressional Caucus on Social Determinants of Health⁵. Our findings support that the focus on partnerships and flexibility to address social determinants of health needs is the right approach.

The NHC fully supports CMS' efforts to improve collection and extraction of data relevant to social determinants of health and underserved populations, including the

³ [NHC-Statement-on-Nondiscrimination-Provisions.pdf \(nationalhealthcouncil.org\)](#)

⁴ <https://nationalhealthcouncil.org/wp-content/uploads/2021/10/Designed-Roundtable-on-Coverage-Recommendations-Final.pdf>

⁵ To be released February 1

proposal to collect and extract five new data elements (zip code, race, ethnicity, individual coverage health reimbursement arrangement (ICHRA) indicator, and a subsidy indicator) in states where HHS is operating the risk adjustment program We also agree that proposed collection of “z codes” could offer increased granularity and improve CMS’ ability to direct equity initiatives to areas of greatest need. We urge CMS to undertake an education and outreach campaign to increase provider awareness of the codes and their appropriate use, as well as to identify any barriers to using the codes.

We appreciate that CMS seeks stakeholder input on ways to incentivize QHP issuers to design plans that address health inequities, including those associated with social determinants of health.

IV. Reinforcing market stability

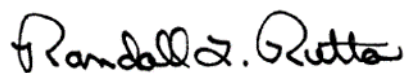
Maintaining user fees at 2022 level

The NHC appreciates that CMS restored user fees in 2022 to a level more likely to capture the costs of operating the exchanges with the restoration of the consumer supports individuals need to make informed decisions, though we note that they are still lower than in prior years. We had previously opposed reductions in user fees, citing the potential that reduced funding would compromise the quality and quantity of information available to individuals as they determine which health insurance plan best suits their needs. We appreciate CMS’ proposal to maintain user fees at the 2022 levels and encourage you to continue to ensure the fee levels are set such that they provide sufficient funding to respond to consumer needs for plan coverage and enrollment information.

Conclusion

We appreciate the opportunity to provide input on the proposed changes impacting health coverage under the ACA. Please do not hesitate to contact Eric Gascho, Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,



Randall L. Rutta
Chief Executive Officer