



Charles N. Kahn III
President and CEO

January 8, 2023

Via electronic submission at <http://www.regulations.gov>

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025 [CMS–9895–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 2025 (Proposed Rule).

Proposals that Promote Enrollment, 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. Accordingly, the FAH is appreciative of and encourages HHS to finalize proposals that would promote enrollment and continuous coverage. For example, the FAH supports the following proposals:

- ***Catastrophic Coverage in the Auto Re-Enrollment Hierarchy.*** The FAH supports auto re-enrollment as a critical tool for ensuring appropriate continuing coverage for individuals year-over-year. To this end, we support the incorporation of catastrophic coverage into the auto re-enrollment hierarchy through the proposed amendments to § 155.335(j).
- ***Annual Open Enrollment Periods.*** With respect to enrollment periods, the FAH likewise supports HHS’ proposal to amend § 155.410(e)(4)(ii) to require that every State Exchange’s open enrollment period extends to at least January 15 of the benefit year. Allowing a State Exchange’s alternative open enrollment period to terminate earlier than the period for Federally-facilitated Exchanges and State Exchanges using the Federal platform creates consumer confusion and compromises robust enrollment. However, the FAH believes that State Exchanges not utilizing the Federal platform should have the flexibility to both continue open enrollment after January 15 and commence open enrollment before November 1. Therefore, the FAH recommends that CMS change “begins on November 1” in proposed 155.410(e)(4)(ii) to “begins on or before November 1” to ensure that State Exchanges continue to have this flexibility.
- ***Special Enrollment Periods (SEPs).*** SEPs help to ensure that consumers have appropriate and continuing access to coverage when circumstances change mid-year, and the FAH supports HHS’ proposed amendments to § 155.420 to align the effective dates of coverage for certain SEPs and to make permanent the SEP for consumers eligible for advance payment of premium tax credits (APTC) with household income at or below 150 percent of the Federal poverty level (FPL). With the end of Medicaid continuous enrollment, SEPs have been a valuable tool to preserving coverage, and the FAH appreciates CMS’ continuing efforts to identify opportunities to better support impacted consumers through aligned effective dates for enrollments during SEPs and a permanent 150 percent FPL SEP.
- ***Exchange Call Centers and Enrollment Platforms.*** The FAH also supports CMS’ proposals to establish additional minimum standards for Exchange call center operations (proposed § 155.205(a)) and to require each Exchange to operate a centralized eligibility and enrollment platform (proposed §§ 155.205(b), and 155.302(a)(1)). These proposals are consistent with current operations and therefore impose minimal burdens, and the FAH supports the formal promulgation of regulations with these requirements and the general standardization of essential consumer assistance, eligibility, and enrollment capabilities across Exchanges.

With respect to premium payment deadline extensions, although the FAH supports providing consumers with opportunities to avoid losing coverage due to late premium payments, the FAH opposes doing so in a manner that creates retroactive terminations or otherwise places providers at risk for coverage during any payment deadline extension. It is the FAH’s understanding that the proposed amendment to § 155.400(e)(2) is not intended to extend the duration of the 3-month grace period described in § 156.270(d) and (g), and that the payment deadline extension would apply *before* the 3-month grace period (if applicable). In other words,

an APTC-eligible consumer has not “fail[ed] to timely pay premiums” under § 156.270(d) unless and until any premium payment deadline extension has been exhausted such that coverage would be maintained during the extension period and the 3-month grace period (if applicable) would necessarily follow the premium payment deadline extension. Any contrary interpretation would render the deadline extension illusory and place the consumer—and the providers that serve the consumer—at risk for non-coverage. If CMS finalizes the proposed amendment to § 155.400(e)(2), the FAH therefore recommends clarifying that any premium payment deadline extension must be exhausted before any 3-month grace period and cannot operate to extend the grace period.

Network Adequacy

The FAH generally supports network adequacy standards that measure access beyond time and distance standards for primary care services. As a positive move in that direction the FAH supports CMS’ proposal to extend FFE Network Adequacy minimum standards to State Based Exchanges and SBE-FP’s and supports future application of appointment wait time standards and inpatient and outpatient procedure wait time standards. The FAH would encourage network adequacy standards that permit only narrow exceptions, and which provide transparency to consumers where exceptions are permitted. Additionally, the FAH would encourage continued audit and oversight of adequacy of providers of inpatient rehabilitation and other post-acute services to measure consumer’s ability to access these network providers promptly with minimal burdens when acute care services are no longer necessary.

Non-Standard Plans

The FAH supports Exchange policies that ensure consumers have a robust choice of plans that offer a broad 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. The FAH does not support limiting the number of non-standardized plan options that a QHP can offer, and while this proposal will provide a limited exception for plans that address a narrow set of chronic and high cost conditions, the proposal will not make up for the estimated 109,229 non-standardized plan options that will be discontinued in PY2025 as a result of limitations on non-standard plans.¹

Rather, the FAH urges CMS to continue to allow plans to propose a broader range of non-standardized plans that are not limited or specifically defined by the condition of the patient. The FAH believes QHP plans were intended to provide a wide range of health benefits not designed for a single condition, but a wide range of conditions as set forth in the ACA. The FAH also supports the enhancement of the choice architecture on HealthCare.gov to support informed choice among consumers. The FAH supports the differential display of standardized options including requiring QHP issuers and web-brokers to differentially display standardized options when a non-FFE Web site is used to facilitate enrollment. While we agree that

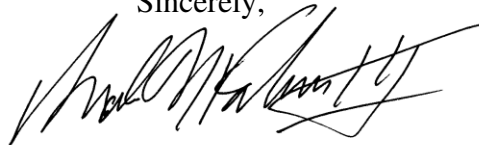
¹ 88 Fed. Reg. at 82,607.

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 current limit on non-standard plan options and the limited exception for plans narrowly tailored for patients with chronic and high-cost conditions.

The FAH appreciates the opportunity to submit these comments on these important issues to patients and providers. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "William H. Bennett, Jr.", written in a cursive style.