The Honorable Xavier Becerra
Secretary
United States Department of Health
and Human Services
200 Independence Ave. SW
Washington, DC 20201

January 27, 2022

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

Dear Secretary Becerra,

The American College of Physicians (ACP) appreciates the opportunity to comment on the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 proposed rule. ACP is the largest medical specialty organization in the United States with members in more than 145 countries worldwide. ACP membership includes 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Guaranteed Availability of Coverage (147.104)

ACP supports the proposal regarding past-due premiums, which would prohibit insurers from denying new coverage for failure to pay outstanding premiums from the past year. This policy may help ensure that individuals experiencing economic insecurity are not denied comprehensive health coverage and are able to access necessary care. Many uninsured adults report affordability as a reason for not enrolling in coverage. The proposal may help individuals achieve economic stability, an important social driver (or determinant) of health, and prevent the consequences of being uninsured, including delayed or forgone receipt of care.

Nondiscrimination Based on Sexual Orientation and Gender Identity (including 147.104(e), 155.120(c), 156.200(e))

ACP strongly supports amendments to prohibit discrimination based on sexual orientation and gender identity. ACP opposes any form of discrimination in the delivery of health care services. Discrimination is a social driver of health, and is associated with negative mental health outcomes for sexual minority populations. National surveys find that transgender and gender

non-identifying individuals report high rates of workplace discrimination, harassment, physical assault, and sexual violence. ACP has expressed strong opposition to efforts to undermine nondiscrimination protections for LGBTQI+ individuals. We agree that this proposal will help prevent discrimination and achieve health equity in the LGBTQI+ population. We support amending 45 CFR 147.104(e) to affirm that "nondiscrimination protections would explicitly prohibit discrimination based on sexual orientation and gender identity." ACP supports the proposal to amend 155.120(c) to "prohibit states and Exchanges carrying out Exchange requirements from discriminating based on sexual orientation and gender identity" as well as the proposal to amend 156.200(e) to prohibit QHP issuers from discriminating based on sexual orientation and gender identity.

Proposals Regarding Web Broker Websites

ACP supports the proposal to amend 155.220 to expand the minimum QHP comparative information display requirements for Web Broker non-exchange websites. The policy would require web-broker websites to present information on premiums and cost-sharing obligations, summary of benefits and coverage, the metal level of the QHP or catastrophic plan, quality ratings, and the "provider" directory. We also support the proposal to require display of the standardized disclaimer noting the availability of Exchange-based enrollment assistance and providing a web link to the Exchange. These policies will help ensure that individuals shopping for coverage are empowered to make an objective health coverage enrollment decision.

Additionally, we support prohibiting web brokers from displaying QHP advertisements or giving preferential placement to QHPs based on compensation from plan issuers. ACP also agrees with the proposal to amend 155.220 to mandate that web broker websites provide rationale for QHP recommendations. These safeguards will help prevent conflicts of interest and ensure individuals enroll in coverage that best meets their health care and financial needs.

Refine EHB Nondiscrimination Policy for Health Plan Designs (156.125)

ACP believes that health coverage benefit packages should emphasize high-value, evidence-based care. We support revising 156.125 to ensure that nondiscriminatory benefit designs providing Essential Health Benefits (EHB) are based on clinical evidence, defined as "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." ACP concurs that peer-reviewed medical journals, such as the Annals of Internal Medicine, and clinical guidelines developed by entities like medical specialty organizations or the United States Preventive Services Task Force, are acceptable sources of reputable clinical information when determining if an issuer's benefit package is discriminatory.

Evidence shows that EHB packages do not always cover evidence-based services. In 2017, ACP released a clinical guideline for noninvasive treatment for acute, subacute, and chronic low back pain that recommended several nonpharmacologic treatments to improve pain and

function. A 2019 study found that many state EHB benchmark plans excluded or placed arbitrary limits on coverage of nonpharmacologic treatments for lower back pain, concluding that, "insurance coverage discourages multidisciplinary rehabilitation for chronic pain management by providing ambiguous guidelines, restricting ongoing treatments, and excluding behavioral or complementary therapy despite a cohesive evidence base." It should also be noted that clinical guidelines can be misapplied and misinterpreted. For example, the Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain was used to justify legislation to establish coverage limits on prescription opioids.

The example of Coverage of EHB for Gender-Affirming Care underscores the need for clear policy to address discrimination in EHB packages. In 2015, ACP noted that state discrimination and insurance coverage laws related to gender identity varied considerably and recommended "gender identity, independent and fundamentally different from sexual orientation, be included as part of nondiscrimination and antiharassment policies [and] public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries." Additionally, we share concern over the discriminatory effects of adverse tiering, including use of step therapy and nonmedical drug switching.

Standardized Options (156.201)

Although ACP has not taken a stance on standardized plans, there are characteristics of standardized plans that align with ACP policy, including simplified design, emphasis on high-value care, and potential to identify and eliminate discriminatory plan structures. Standardized cost sharing structures enable individuals to compare plans based on quality and "provider" networks. We agree with requiring first-dollar (pre-deductible) coverage of high-value services, including primary care visits, to encourage their use. This concept could be explored further. Standardized plans could adopt value-based insurance design strategies that reduce or eliminate out-of-pocket contributions for services proven to offer the greatest comparative benefit, with higher cost-sharing for services with less comparative benefit. Such strategies should be based on rigorous comparative effectiveness research by independent and trusted entities that do not have a financial interest in the results of the research. The goal should be to ensure that high-value cost-sharing strategies encourage enrollees to seek items and services proven to be of exceptional quality and effectiveness and not just based on low cost.

Network Adequacy (156.230)

ACP supports the proposal to strengthen network adequacy oversight, including implementing robust federally facilitated exchanges (FFE) network adequacy reviews and using of quantitative criteria to determine network adequacy. We have long been concerned about the proliferation of QHPs with narrow networks. Narrow network plans typically have lower premiums than broad network plans but they also restrict access to in-network physicians and may create market conditions that force broad network plans out of the Exchange. ACP has called for stringent quantitative network adequacy criteria; ongoing monitoring and oversight of

"provider" networks; transparent "provider" network development criteria; accurate, easily accessible and up-to-date "provider" directories; and requirements that QHPs should be prohibited from excluding health care clinicians whose practices contain substantial numbers of patients with expensive medical conditions.

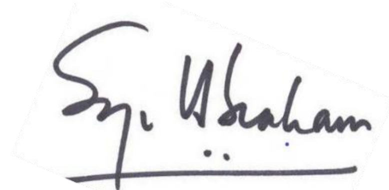
We previously supported FFE review of quantitative network adequacy standards in the Payment Parameters for PY2017 proposed rule and opposed the changes made under the Market Stabilization final rule that restricted federal network adequacy review and weakened enforcement. Although ACP does not have sufficient policy to recommend specific quantitative standards for determining network adequacy, we note that maximum time and distance and appointment wait time are common standards used by states, Medicaid, and Medicare Advantage to determine network adequacy. ACP believes that tiered networks must be closely regulated to prevent discrimination against vulnerable patients, such as adults with chronic conditions, and ensure access to all covered services, including specialty care. Network adequacy standards should apply to the lowest cost-sharing tier of any tiered network.

Solicitation of Comments on Health Equity, Climate Health, and Qualified Health Plans

ACP believes QHPs can play a role in advancing health equity. More research and data collection related to racial and ethnic health disparities are needed to empower policymakers and stakeholders to better understand and address the problem of disparities. Collected data must be granular and inclusive of all personal identities to more accurately identify socioeconomic trends and patterns. Having access to data at the racial level is essential to identifying health trends among certain populations and offering targeted interventions and treatments to ameliorate racial and ethnic health disparities. However, there are many challenges and shortcomings to current data collection practices and national standards that pose barriers to effectively using it for these purposes. While some data are tracked at the national level, administrative data from insurance claims and medical records, which may include incomplete information, are heavily relied upon for tracking disparities at the state and local levels.

Thank you for the opportunity to comment on the proposed rule. Please contact Ryan Crowley, Senior Associate for Health Policy at rcrowley@acponline.org if you have questions.

Sincerely,



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