AIMED ALLIANCE

January 27, 2022

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

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard,
Baltimore, MD 21244

Re: HHS Notice of Benefit and Payment Parameters for 2023 – CMS-9911-P

Dear Secretary Becerra and Administrator Brooks-LaSure:

Aimed Alliance is a 501(c)(3) not-for-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. We appreciate the opportunity to comment on Docket CMS-9911-P the *HHS Notice of Benefit and Payment Parameters for 2023* (NBPP). We support:

I. **Clarifying that discrimination based on sex includes discrimination based on sexual identity and gender identity;**
II. **Strengthening EHB protections and addressing discriminatory benefit designs;**
III. **Ensuring that health plans do not improperly incentivize virtual versus in-person healthcare visits**;
IV. **Tracking how technology in healthcare can play a role in ensuring network adequacy requirements are met; and**
V. **Standardizing health plans offered on the federal exchange.**

In addition, we also urge the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) **to prohibit copay accumulator programs** in the final 2023 NBPP.

I. Ensuring That Individuals Are Protected from Plan Discrimination Based on Sexual Orientation and Gender Identity Is an Important Civil Rights Protection.

Under Section 1557 of the Patient Protection and Affordable Care Act (ACA), health plans are prohibited from discriminating against an individual based on race, color, national origin, sex, age, or disability.[1] However, in recent years, the definition of "sex" has, on occasion, been interpreted narrowly to exclude discrimination based on "sexual orientation" and "gender

[1] HHS, *Section 1557 of the Patient Protection and Affordable Care Act*, https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

identity." Consequently, individuals who have non-cisgender identities and identify as LGBTQ+ often experience discrimination in accessing inclusive healthcare.[2] As a result of an inability to access care, one study found that LGB individuals were at heightened risks of experiencing psychological distress, while lesbian and bisexual women were at a heightened risk of developing multiple chronic conditions.[3] Untreated chronic conditions are dangerous and can lead to a reduced quality of life, premature mortality, and reduce an individual's overall health.[4] In addition, untreated chronic conditions can also lead to the development of co-occurring conditions, as well as impose a large financial burden on the U.S. healthcare system.[5]

Aimed Alliance strongly supports the 2023 NBPP proposal to amend 45 CFR 155.120(c) to explicitly state that nondiscrimination protections apply to both sexual orientation and gender identity.[6] We thank HHS for this clarification as it will help increase access to treatment for chronic conditions and ensure that an individual's access to healthcare is not inhibited by discriminatory practices based on gender identity or sexual orientation.

II. HHS Should Strengthen Protections for Essential Health Benefits.

One of the many crucial healthcare protections created by the Patient Protection and Affordable Care Act (ACA) was the creation of the ten essential health benefit (EHB) categories. The creation of the ten EHB categories ensured that individual and small group health plans provided comprehensive coverage of these ten essential healthcare needs. Prior to the creation of EHBs, many individuals did not have access to these crucial healthcare services; for example, only 1 in 3 individuals in the individual market had access to substance use disorder treatment.[7]

To ensure genuine access to these ten EHBs, the ACA also prohibits health plans from developing plans with a discriminatory benefit design. Historically, states have had the primary responsibility for monitoring plans to ensure they comply with the ACA non-discriminatory benefit design requirements. As a result, states have adopted a wide variety of approaches from conducting comprehensive reviews of plans to more simply requiring certain model plan language to be adopted in each plan.[8] However, in a study of a select group of five states, four out of the five state regulators reported that their lack of clinical experience made it difficult to ensure plan compliance with the non-discriminatory requirement.[9] The 2023 NBPP would

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[2] HRW, *"You Don't Want Second Best" Anti-LGBT Discrimination in US Health Care,* https://www.hrw.org/report/2018/07/23/you-dont-want-second-best/anti-lgbt-discrimination-us-health-care. .
[3] *Id*.
[4] *The effects of undertreated chronic medical illnesses in patients with severe mental disorders,* https://pubmed.ncbi.nlm.nih.gov/19570498/.
[5] *The Growing Crisis of Chronic Disease in the United States,* https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf.
[6] HHS, *2023 NBPP*, https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023.
[7] Center for Am. Progress, *10 Ways the ACA Has Improved Health Care in the Past Decade,* https://www.americanprogress.org/article/10-ways-aca-improved-health-care-past-decade/.
[8] Georgetown University, *The Affordable Care Act prohibits discriminatory benefit design, but how is that enforced?*, http://chirblog.org/the-affordable-care-act-prohibits-discriminatory-benefit-design-but-how-is-that-enforced/.
[9] *Id.*

require that plan design be based on evidence-based guidelines, such as journal articles, practice guidelines, recommendations from reputable professional associations, or similar sources.[10] Aimed Alliance supports requiring benefit designs to be based on evidence-based guidelines as this requirement provides a clearer means for both state and federal regulatory agencies to determine whether a plan's design operates in a discriminatory manner, or whether the policy is supported by clinical evidence.[11]

III. Telehealth Can Help Expand Access to EHBs But Should Not Improperly Incentivize Virtual Visits Over In-Person Visits.

During the beginning of the COVID-19 pandemic, telehealth became a prominent tool to help ensure continued access to treatment for patients while limiting their COVID-19 exposure risks. While telehealth will remain an important tool in the future of healthcare for both expanding access to care for patients and helping address access-related health disparities, it should not interfere with the patient and provider relationship and their shared decision making on the best way to treat the patient.[12]

The 2023 NBPP notes that some insurers have begun to design plans to provide for zero copays when a patient receives a virtual service but requires a copay for an in-person visit. There are multiple problems with this type of plan structuring. First, for many, the establishment of an in-person relationship between a provider and patient may be medically necessary for proper diagnosis and treatment. For example, providers may, in some instances, need to physically examine their patients or conduct tests, in which case an in-person visit may be required. Second, the decision as to whether an in-person visit or a virtual visit is appropriate should be a decision between the patient and the provider, and not influenced by the health plan's preference for virtual visits versus in-person visits. This type of preferential copay structuring could result in patients not accessing in-person care when it is deemed medically necessary by a provider or preferred by the patient. Aimed Alliance encourages CMS and HHS to continue to monitor this issue closely and ensure that the decision for an in-person or virtual visit is made between the healthcare provider and the patient, based on medical necessity and convenience, and not based on preferential plan structuring.

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[10] HHS, *2023 NBPP*, https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023.

[11] Georgetown University, *The Affordable Care Act prohibits discriminatory benefit design, but how is that enforced?*, http://chirblog.org/the-affordable-care-act-prohibits-discriminatory-benefit-design-but-how-is-that-enforced/.

[12] Aimed Alliance, *Telehealth in a Post-Pandemic World: Preserving Gains and Ensuing Access to In-Person Care Executive Summary*, https://aimedalliance.org/wp-content/uploads/2021/09/Telehealth-Executive-Summary-FINAL-9.13.21.pdf.

IV. Determining Network Adequacy Should Include Tracking of Telehealth Data and the Use of Prescription Digital Therapeutics.

Qualified health plan issuers are required to maintain a network of providers who offer primary and specialty care to ensure that all services are available without unreasonable delay.[13] In the 2023 NBPP, HHS proposes to conduct quantitative network adequacy reviews and expand this review to include the use of telehealth by providers to inform future network adequacy and provider access standards. [14] Aimed Alliances supports the inclusion of tracking telehealth data as part of network adequacy. Aimed Alliance encourages HHS to also track the use of prescription digital therapeutics (PDTs) to inform future network adequacy and provider access standards. PDTs are Food and Drug Administration cleared therapeutics that can be accessed through technology to prevent, manage, or treat a wide range of diseases and disorders such as ADHD, amblyopia, autism, chronic low back pain, irritable bowel syndrome, opioid use disorder, and substance use disorder.[15] Like telehealth, PDTs expand access to care for patients and help reduce access-related health disparities. As the future of healthcare continues to evolve and the use of technology within healthcare expands, we encourage HHS to actively track the use of telehealth as well as PDTs to ensure the adequacy of provider networks and that qualified health plan consumers have access to needed care without unreasonable delay.

V. Standardization Helps Consumers Pick the Plan That Is Best for Their Needs.

For many consumers, choosing the right health plan can seem very complicated as plans include a variety of cost-sharing language and terms with which consumers may be unfamiliar. Studies have found that, as a result of this confusion, consumers can unknowingly choose more costly coverage than necessary.[16] This confusion can also be exacerbated by the recent growth of plan options on the federal marketplace from 60 options to now more than 100.[17] Standardized plans can help alleviate this confusion for consumers by having uniform maximum out-of-pocket limits, deductibles, and cost-sharing for a given level of coverage.[18] Currently, nine states' exchanges (including the District of Columbia) have recognized the benefits that standardization provides to consumers, and have required insurers to offer standardized plans.[19]

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[13] NCSL, *Insurance Carriers and Access to Healthcare Providers*, https://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx#:~:text=Network%20adequacy%20refers%20to%20a,the%20terms%20of%20the%20contract..

[14] HHS, *2023 NBPP*, https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023.

[15] Aimed Alliance, *ACTION for PDTs*, https://aimedalliance.org/action-for-pdts/.

[16] Forbes, *Health Insurance Confusion Continues to Plague American, New Data Show*, https://www.forbes.com/sites/debgordon/2021/02/08/health-insurance-confusion-continues-to-plague-americans-new-data-show/?sh=17641f814667.

[17] ASPE, *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplace*, https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.

[18] *Id.*

[19] The Commonwealth Fund, *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities*, https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans.

The 2023 NBPP would require insurers on the federal exchange to offer standardized plans and require all federally regulated plans to have one standardized option that has copay only cost-sharing for all drug tiers, including specialty drugs.[20] For many, the copay option is better than coinsurance, as it allows consumers to know from the beginning of the plan year the maximum flat rate they will be expected to pay at the pharmacy counter. Including specialty medications in standardized plans is also important for improving costs for patients with chronic conditions who are otherwise more likely to have a higher co-insurance rate for their specialty medications.[21] Aimed Alliance supports the standardization of plans as it helps consumers reduce their out-of-pocket costs, and make clearer and more informed choices about their healthcare coverage.

VI. Failure to Prohibit Copay Accumulator Programs Harms Patients.

When patients cannot afford their medications due to high copays or costly co-insurance rates, they may rely on financial assistance, often referred to as copay assistance, from pharmaceutical manufacturers or other third parties to help meet their cost sharing responsibilities and fill their prescriptions. Typically, the contribution of this assistance should count towards meeting the individual's deductible and annual out-of-pocket maximum. These programs have been especially helpful for individuals who participate in a high deductible health plan (HDHP). HDHPs have high out-of-pocket costs until the deductible is reached. HDHPs are also becoming more common among employers, with one survey finding that, on average, more than fifty percent of individuals who receive health insurance from an employer are enrolled in an HDHP.[22] While copay assistance should help individuals with HDHPs, health insurers have been continuing to enact copay accumulator programs that prohibit this third-party assistance from counting towards the individual's deductible and annual out-of-pocket limit. Essentially, under these copay accumulator programs, the health insurer deprives the individual of the full benefits of the copay assistance and takes the copay assistance for itself. For individuals, this means that they will be required to pay more out-of-pocket before their deductible is met.

In the 2020 NBPP, HHS announced that copay accumulator reform would be left to the states. Since this decision, twelve states plus Puerto Rico have enacted copay accumulator reform laws to prohibit health plans from excluding copay assistance from the individual's cost-sharing requirement and annual out-of-pocket limit. In 2022, we will continue to encourage more states to introduce and adopt similar legislation.[23] Aimed Alliance is disappointed that HHS did not protect consumers in the 38 states without copay accumulator reform laws by addressing copay accumulators in the 2023 NBPP. We encourage HHS to reconsider prohibiting copay accumulators in the final 2023 NBPP given the clear need for nationwide reform.

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[20] HHS, *2023 NBPP*, https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023.
[21] AIS Health, *Coinsurance Was Main Pharmacy Benefit Specialty Cost Share Tool*, https://aishealth.com/drug-benefits/coinsurance-was-main-pharmacy-benefit-specialty-cost-share-tool/.
[22] Value Penguin, *High-Deductible Health Plans Continue to Grow in Popularity, but Are They Right for You?*, https://www.valuepenguin.com/high-deductible-health-plan-study#How.
[23] Aimed Alliance, *Copay Accumulators – Enacted Laws*, https://aimedalliance.org/copay-accumulators-enacted-laws/.

Without a federal ban on copay accumulator programs, patients will continue to struggle to access their medications and be forced to pay higher out-of-pocket costs for their healthcare. Failing to address copay accumulator programs is also harmful to individuals who were affected, and who remain impacted, by the COVID-19 pandemic. For example, a 2021 survey found that during the COVID-19 pandemic, 20.6% of people surveyed had difficulty affording basic necessities like food and housing, due to the high cost of their prescription medications.[24] For many individuals and families, the COVID-19 pandemic has drained savings accounts and left people struggling to afford their basic necessities and healthcare.[25] By ensuring all copays count towards an individual's annual out-of-pocket maximum and deductibles, patients will be able to satisfy their cost-sharing limits earlier, which will allow many families and individuals to provide for other necessities. Thus, we encourage HHS to reconsider prohibiting copay accumulator programs in the 2023 NBPP.

VII. Conclusion

In conclusion, Aimed Alliance supports the steps HHS and CMS have taken to protect and expand healthcare coverage and affordability for consumers. In addition, we urge both HHS and CMS o go further and prohibit harmful copay accumulator programs by ensuring that all contributions on behalf of the patient's cost-sharing requirement count for the patient and not merely enrich the health insurer.

Sincerely,

Ashira Vantrees

Ashira Vantrees
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[24] GoodRx, *Survey: Americans Struggle to Afford Medications as COVID-19 Hits Savings and Insurance Coverage*, https://www.goodrx.com/healthcare-access/drug-cost-and-savings/survey-covid-19-effects-on-medication-affordability.
[25] *Id.*