FLORIDA HOSPITAL ASSOCIATION
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AN ASSOCIATION OF
HOSPITALS & HEALTH SYSTEMS

January 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244

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

Dear Administrator Brooks-LaSure:

On behalf of our more than 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates the opportunity to provide comments on the proposed rule, CMS-9899-P: Patient Protection and Affordable Care Act Notice of Benefit and Payment Parameters for 2024. Rules governing the products sold on the Federally Facilitated Marketplace (FFM) are of critical interest and importance to our member hospitals. With 3.3 million Floridians signing up for coverage through the FFM, which represents 27% of Floridians not covered by Medicare and Medicaid, requirements for these plans have great impact on the care provided by hospitals and their related organizations.

FHA appreciates efforts by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services' continued efforts to increase access to health care services, simplify choice and improve the plan selection process, making it easier to enroll in coverage. We generally support the Agency's efforts to ensure that FFM plans provide adequate networks, ease of use, and importantly that no-network plans are no longer permitted on the marketplace. We have provided specific comments below.

Network Adequacy
Ensuring there are enough providers to serve the population enrolled in a heath plan is critical to access to care. FHA strongly supports the proposal to require all Qualified

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Health Plans to comply with the network adequacy and essential community providers (ECP) standards. We applaud CMS for specifically stating that no-network plans, such as reference-based pricing plans, could no longer be sold on the marketplace. Our hospitals have shared stories about consumers not understanding what is covered by no-network plans, and are caught off guard when they become aware of the additional cost burden of these plans.

Essential Community Providers
The need for behavioral health and substance use disorder treatment and care has grown tremendously during the pandemic. **We strongly support the proposal to add the two new categories of essential community providers (ECP)**, mental health facilities and substance use disorder treatment centers to the category of ECP. We also support the addition of the Rural Emergency Hospital to the list of other ECPs.

Standardized Plan Options
FHA supports CMS's efforts to standardize plan options. In Florida, there are 14 insurers offering multiple plan options; the volume of plans to choose from can be confusing to navigate for individuals and families who are not conversant in the language of health insurance. While Florida is fortunate enough to have a very experienced group of navigators and CMS's campaigns have increased awareness of assistance available to help with plan selection, too many options make picking plans challenging.

FHA applauds the proposal requiring issuers to offer standardized Qualified Health Plan (QHP) options designed by CMS at every product network type, at every metal level except the non-expanded bronze level and throughout every service area they offer non-standardized QHP options. Additionally, we support limiting the number of non-standardized plan options to two per product type, metal level in any service area. This will reduce the likelihood of consumers being overwhelmed by so many choices and increases the chances of selecting the most appropriate plan for their needs.

Standardized plan options and a more manageable number of plan choices for consumers would streamline the selection process and allow consumers to more easily select a plan that best fits their health coverage needs.

Making it Easier to Enroll in Coverage
Having health care coverage increases the likelihood of seeking primary and preventive care. Without coverage, people delay care until they are very sick, likely turning to the hospital emergency services for care. **FHA supports any strategy or approach which helps those eligible to sign up or enroll in health insurance coverage.**

Given 1.7 million Floridians, currently covered under Medicaid, could lose their coverage starting in April due to eligibility redetermination, we support the proposal to allow Marketplaces to implement a special rule for consumers losing Medicaid or Children's Health Insurance Program (CHIP) coverage beginning January 1, 2024. This would provide consumers 60 days before or 90 days after their loss of coverage to select a plan via a special enrollment period.

CMS proposes to change the current coverage effective date requirements to allow the option to offer earlier coverage effective start dates for a future loss of minimum essential coverage. **If Medicaid coverage ends mid-month, then market place plans would be allowed to enroll those individuals at the beginning of the month prior to losing coverage.** We support this proposal to prevent any gaps in coverage for those losing their Medicaid benefits.

Funding for the navigators or assisters has been critical to helping people understand their options and sign up for coverage. Currently, assisters are prohibited from enrolling people in coverage even though they are allowed to conduct door-to-door outreach, education and schedule follow-up appointments. **Allowing door-to-door enrollment during the first contact would reduce the burden of having to schedule a separate time to sign up for coverage.** We support this change since it allows consumers to receive more timely enrollment assistance.

Establishing a Timeliness Standard for Notices of Payment Delinquency
Those with coverage through the Marketplace are provided with a three-month grace period to pay their premiums, during which, if they paid all outstanding premiums before the end of the three months, they would return to good standing. During this period, providers are at risk for non-payment of claims if the outstanding premiums are not paid and they lose coverage. We believe this grace period will ultimately help patients and support its inclusion in the rule, however, CMS should make clear that care delivered by providers during that period will be reimbursed.

CMS is proposing to add a timeliness standard to the requirement for QHP issuers to send enrollees a notice of payment delinquency. Currently, issuers are required to notify but the regulations do not specify a timeframe for notification. CMS is seeking comments on what a reasonable timeframe for sending notices of delinquency to enrollees. We recommend these should be sent within five (5) business days after the payment was due.

The federal marketplace is a source of insurance for millions of the patients our hospitals serve. We support these efforts to help consumers with understanding and selecting the plan best suited to meet their needs and ensuring there is an adequate network of essential providers to provide the care they need.

Thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact Michael Williams at mwilliams@fha.org.

Sincerely

Mary C. Mayhew
President and CEO
Florida Hospital Association