American Heart Association | American Stroke Association

December 21, 2012

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
ATTN: CMS-9980-P
PO Box 8010
Baltimore, MD 21244-8010

RE: File Code CMS-9980-P (Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation)

Dear Secretary Sebelius:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate this opportunity to offer our comments on the Department of Health and Human Service's proposed rule, "Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation."

The AHA/ASA has long advocated for all Americans to have access to affordable, adequate, quality health insurance coverage. This is critical to the AHA/ASA's goal of improving the cardiovascular health of all Americans and reducing cardiovascular and stroke mortality by 20 percent. The essential health benefits (EHB) package, actuarial value (AV) determinations, and the accreditation of qualified health plans (QHPs) will all play important roles in making quality insurance coverage available to millions more people, and we welcome this opportunity to comment on the proposed rule.

§147.150 Coverage of essential health benefits

We support the proposed rule's requirement that issuers offering individual or small group health insurance coverage inside or outside of the Exchange must offer the EHB package, as required by the ACA and needed for reducing the potential of adverse selection. An estimated 68 million Americans will obtain insurance coverage that must meet the EHB requirements. In addition, the EHB requirements have implications for the implementation of many other important protections in the Affordable Care Act (ACA), such as the ban on annual dollar limits on EHB services and the establishment of out-of-pocket limits. Therefore, we view the defining of the EHB package as among the most important regulatory tasks required by the ACA.

We also support the proposal that issuers offering any level of coverage in the exchange must offer coverage in that same level to children under age 21, which will ensure the availability of child-only coverage.

§155.70 Additional required benefits

We support making the definition of state-required benefits specific to care, treatment and services that a state requires issuers to offer to enrollees; we believe it is appropriate to exclude state rules related to provider types, cost-sharing or reimbursement methods.

§155.1045 Accreditation timeline

In general, we agree with the establishment of the timeframe within which a QHP that is not already accredited must become accredited in order to participate in a federally facilitated exchange (FFE). We also believe state-based exchanges should be required to have comparable, specific timelines in place. Accreditation is an important tool for ensuring that QHPs are providing high quality care and good customer service, although not a substitute for the broader quality reporting requirements of the ACA.

We also want to use this opportunity to strongly encourage the Department to move forward as swiftly as possible on implementing the range of exchange quality requirements included in the ACA, rather than waiting until 2016. Research shows that, once consumers choose a health plan, they are unlikely to switch coverage. (For example, a number of studies found that only between 1% and 4% of employees with a choice of coverage changed plans from one year to the next.) Therefore, it is important that as much reliable quality information as feasible be available to consumers when they start shopping for coverage in October 2013 in order to enable them to make an initial plan choice that is based on quality and not just cost. We will be making more extensive comments and recommendations on this issue in response to the Department's "Request for Information Regarding Health Care Quality for Exchanges."

§156.20 Definitions

We agree with the proposed rule that HHS should assure that every EHB package must cover the 10 statutorily-required categories of service. We note, however, that this definition also includes limits associated with the covered benefits. These limits should not be incorporated wholesale into the EHB package. Arbitrary and unreasonable limits could be used to restrict needed care – inconsistent with the ACA's clear intention to guarantee that at least the 10 benefit categories are consistently covered – or steer consumers into or away from certain plans. In some instances, arbitrary service limits could seriously interfere with necessary care. For example, heart attack and stroke patients frequently face arbitrary quantitative limits on the amount of cardiac rehabilitation or physical, speech, and occupational therapy services they can receive, even when such care is medically necessary for their continued recovery. At a minimum, HHS and the states should closely monitor the use of limits by QHPs to ensure that they are not being used to discriminate against enrollees because of a disability or health condition.

We are further concerned that the proposed rule does not include definitions of the 10 statutory categories. We believe HHS should precisely define the scope and services within each of the 10 benefit categories to ensure that the covered services are at a minimum the same throughout the country in each state's EHB package. This type of additional definition is not inconsistent with the benchmark approach and is necessary to ensure that there is adequate coverage within a category and that there is balance between the categories, as required by the law. Without clear definitions, it will be impossible to hold QHPs accountable for fulfilling a benefit category. Because health plans do not categorize their services within the same benefit categories or use the same terminology as the statute, without clear definitions of categories it is unclear how a state's final EHB package

could be compared to QHP benefits to ensure that they comply with the ACA. Also, without further definition of the categories, how will states or HHS determine whether a QHP's substitution of benefits is occurring within a category, which is permissible, or across categories, which would not be allowed?

For example, some items and services, such as cardiac rehabilitation, durable medical equipment, hospice or skilled nursing services, and certain preventive services may fall under multiple categories or may not fit neatly within any single category. In our examination of state benchmark options, it was often not clear, for instance, that the proposed benchmark covers cardiac rehabilitation services following a heart attack, coronary artery bypass surgery, or other cardiac events. To give you a sense of our findings, based on the information that CMS has made publicly available on its website for each state's proposed benchmark plan:

- A few states (e.g. FL, NC) specifically include cardiac rehabilitation as a covered service under the "outpatient rehabilitation services" benefit.
- Other states (e.g. CA, PA) include "outpatient rehabilitation services" as a covered benefit but while they mention other types of services as being included (i.e. physical therapy, occupational therapy, and speech-language services), they do not mention cardiac rehabilitation as being covered *or* excluded. Are we to therefore assume that cardiac rehabilitation is not covered or perhaps covered under a different category?
- Yet other states (e.g. KS, MI, TX) include "outpatient rehabilitation services" as covered services but do not specifically define what types of rehab are covered or excluded under this benefit. Are we to assume that because cardiac rehabilitation isn't specifically excluded that it is covered without limits (which quite frankly seems unlikely)?

We urge you to clarify in the final rule that cardiac rehabilitation is required to be covered under the EHB benchmark under the rehabilitative and habilitative services category and to ensure that the scope of coverage of this benefit is adequate (a full course of cardiac rehabilitation is generally 36 sessions in 12 weeks). Research has shown that participating in cardiac rehabilitation can reduce cardiac mortality by as much as 31% and it has also proven beneficial in preventing a second heart attack. Despite the clear benefits of cardiac rehabilitation, the use of such programs remains dismally low. Of eligible patients, only 14% to 35% of heart attack survivors and 31% of patients after coronary bypass surgery participate, and lack of insurance coverage or inadequate insurance coverage is frequently cited by patients as a reason for not participating.

To further illustrate our concern about the lack of definition of the categories of services, tobacco cessation pharmacotherapy may be listed under prescription drugs (or not be covered at all) and tobacco cessation counseling may fall under preventive services. Other smoking cessation aids, such as patches, gums, and nasal sprays, may fall under preventive services or fall through the cracks. Other screening tests (e.g. lipid panel, A1c) may fall under either preventive services or laboratory tests, depending on whether they are being used for routine screening or diagnostic or monitoring purposes.

§156.100 State selection of benchmark

AHA believes that deferring the definition of the EHB package to the states rather than having a nationally defined set of EHB services is a missed opportunity for several reasons. First, this approach will make it more difficult to promote value and evidence-based cardiovascular disease (CVD) care to all Americans. This will be particularly true for 2014 and 2015, when each state's EHB package will be based on the benefits offered by the selected benchmark at the time of its

selection. We are concerned that this essentially means that benefits will not be updated during this time to reflect advances in science and medical evidence.

You specifically invited comment on the process for updating the EHB over time. AHA recommends the use of the benchmark framework as a temporary approach. For 2016 and beyond, we strongly recommend that HHS define a national EHB package that become more specific and evidence-based over time, as recommended by the Institute of Medicine. AHA supports the creation of an ongoing advisory committee or council that would monitor the EHB implementation and make recommendations for updating the EHB package to address gaps in coverage and to evaluate benefit designs and service trends. This approach would also allow the EHB package to be adjusted to reflect advances in medical evidence or scientific advancement. The advisory panel should include experts with a wide range of medical expertise that represent the health care needs of diverse segments of the population.

§156.110 EHB-benchmark plan standards

If a base-benchmark plan option does not cover ***any*** items and services within an EHB category, the state must supplement the base-benchmark plan by adding that particular category in its entirety from another benchmark plan option. Likewise, HHS will supplement a default base-benchmark plan but only if the default plan doesn't cover any items or services in a category. We are very concerned that this policy doesn't take into account situations where a category of coverage is inadequate and provide for supplementing in those situations. For example, as we discussed previously, it is not clear whether all of the proposed base-benchmark plans cover cardiac rehabilitation, a cost-effective and evidence-based service. In instances like that, there should be a process for HHS or the states to supplement a category for which there is coverage that is inadequate.

We strongly support the requirement that the EHB not discriminate in its benefit design or implementation of its benefit design based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Moreover, we support requiring EHB issuers to comply with the requirements of §156.200(e), which prohibits discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, and §156.225, which prohibits issuers from using marketing practices or benefit designs that would discourage the enrollment of individuals with significant health needs. The rule also proposes that the EHB-benchmark plan be required to ensure an appropriate balance among the EHB categories, as required by the statute. In order to enforce these important protections, HHS should establish ongoing mechanisms to regularly track access to health care services, and in particular, whether patients have difficulty accessing needed services for reasons of coverage or cost.

We are pleased that the proposed rule recognizes that many plans, including many of the proposed EHB base-benchmark plans, do not currently cover habilitative services and devices, so HHS is therefore proposing a transitional policy for the coverage of these services. However, we are very concerned that HHS is leaving too much flexibility to the states and to issuers, with the result being that patients will continue to have difficulty accessing these services. Access to appropriate habilitative and rehabilitative therapy is a critical element of care that minimizes disability and promotes the productivity of patients with many different conditions. This issue is particularly important to stroke patients, both adults and children.

More specifically, states are given an option to determine the habilitative services to be covered in this category. However, if states choose not to define this category, plans will decide what to cover.

We recognize that many states have already been struggling with how to provide for this coverage in a way that meets the care and treatment needs of people living with chronic conditions and disabilities, and given the many issues facing states, we think it likely that many states will simply decline to define the specific services to be covered. Consequently, this decision will be left up to issuers – the vast majority of which do not currently cover these services and will have an incentive to cover as few services as possible in order not to attract patients with disabilities.

For these reasons, we think it is critically important that the final rule do more to ensure adequate coverage of habilitative services by health plans. Specifically, HHS should include a definition of habilitative services in the final rule. AHA/ASA supports the definition of habilitation services that has been developed by the National Association of Insurance Commissioners (NAIC)[1]. Also, as a floor for coverage, we strongly recommend requiring that habilitative services be offered at parity with rehabilitative services. If states or issuers then want to further define habilitative services, then they could have the flexibility to do so.

§156.115 Provision of EHB

The rule proposes that plans may have limitations on coverage that differ from the EHB-benchmark plan (including limits on amount, duration, and scope of covered benefits) but covered benefits must be actuarially equivalent to those covered by the EHB-benchmark plan. Earlier in this letter, we expressed concern about the inclusion of limits in the definition of covered benefits (see discussion under §156.20). We are also concerned that it will not be possible to verify the actuarial equivalence of treatment limits. It is not clear that a determination of actuarial equivalence can be made for a specific benefit limit (as opposed to a package of benefits and cost-sharing). And even a limit that is actuarially equivalent when measured for a standard population could be grossly inadequate for many individual consumers.

We appreciate the clarification that a plan required to offer the EHB must provide all preventive services described in §147.130 without cost-sharing, as we recommended in previous comments. The ACA is very clear that the process for defining and updating these services and their definition is outside of the EHB process. The recommendations that define these services (by the U.S. Preventive Services Task Force (USPSTF) and other entities, as required by statute) may include recommendations for how often a certain preventive services should be provided. Given the incorporation of such details in the definitions of these services, any limits allowed as a part of the EHB cannot be applied to the Section 2713 preventive health services. For example, when it comes to tobacco cessation services, which have received an "A" recommendation from the USPSTF, several attempts are usually necessary to successfully quit smoking, and the frequency and duration of treatments should not be limited. Limiting the benefit with preauthorization requirements or other unreasonable limits deters people from using these preventive services and should be prohibited unless consistent with the recommendations of the entity given responsibility in the ACA for defining them.

In our examination of many of the state EHB base-benchmark packages, it was often very unclear specifically what preventive health services are covered and what the scope and limits on this coverage may be. For instance, many plans merely included a blanket statement such as

[1] The NAIC defined "Habilitation Services" as "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."

"preventative services mandated by the ACA are covered," but did not explicitly state what services are covered or excluded and sometimes the available information was contradictory.

Current coverage of tobacco cessation helps illustrate our point about why further definition of preventive services is needed under the final EHB rule to ensure that comprehensive services are available. Nearly one-third of the estimated 443,000 deaths each year that are caused by smoking-related illnesses are CVD-related. Quitting tobacco use leads to increased employee productivity, less disability and chronic disease, and less medical expenditures. Increasing the number of successful attempts to stop tobacco use will have an important effect on health and health care costs. Tobacco users vary in what tobacco products they use, how much, how often, and in what coexisting medical conditions they may have. When quitting, they need access to a range of treatments, both medication and counseling, to find the most effective tools that work for them. The covered benefit should include all over-the-counter (OTC) and prescription medications approved by FDA (including combination use) and multiple face-to-face counseling sessions conducted by a qualified health professional.

Despite the evidence that supports coverage of tobacco cessation and the fact that the USPSTF recommendation covers both pharmacotherapy and counseling for tobacco cessation, current health plan coverage of these services is very uneven. In our examination of the proposed EHB benchmark plans, 20 states' benchmarks appear to cover no medications for tobacco cessation, and for 18 states, there was no mention of tobacco cessation in the summary plan information made available on the CMS website (which we recognize does not mean these services are not covered but how will other plans required to provide the EHB know exactly what they must cover?).

A recent study conducted by the Georgetown University Health Policy Institute for the Campaign for Tobacco-Free Kids also found inconsistency in the coverage of tobacco cessation services in the contracts they examined of plans required to comply with Section 2713 of the PHS Act.

- While 36 contracts indicated that they covered tobacco cessation or are providing coverage consistent with the USPSTF recommendations, 26 of these contracts also included language entirely or partially excluding tobacco cessation from coverage.
- There was wide variation in coverage for cessation counseling and medication, raising concern that treatments found to be effective by the USPSTF and required under the ACA are not being covered. Only four of the 39 plans stated they covered individual, group and phone counseling and both prescription and OTC medications. Many policies specifically excluded certain types of counseling and provided no coverage of prescription and OTC medications for tobacco cessation.
- In apparent conflict with the ACA, some policies included cost-sharing requirements. Seven of 36 contracts that clearly covered counseling required cost-sharing for counseling by in-network providers, and six of 24 contracts that covered prescription drugs required cost-sharing.[2]

As this information illustrates, we need more specificity and detail on the preventive services covered by the base-benchmark plan in order to accurately evaluate it, and consumers will need this information in order to take full advantage of these benefits. The final rule should require issuers providing the EHB to specifically state what preventive services are covered and that coverage is provided without imposing any cost-sharing. With respect to tobacco cessation,

[2] Kofman, M., Dunton, K., and Senkewicz MB. "Implementation of tobacco cessation coverage under the Affordable Care Act: Understanding how private health insurance policies cover tobacco cessation treatments." November 26, 2012. Accessed online at: http://www.tobaccofreekids.org/pressoffice/2012/georgetown/coveragereport.pdf.

guidance issued by the Office of Personnel Management (OPM) for the Federal Employees Health Benefits Program is an excellent model for HHS to use to help define the scope of coverage required by the ACA. OPM has instructed insurers to cover at least two quit attempts per year with up to four cessation counseling sessions of at least 30 minutes each (including individual, group and phone counseling). They must also cover OTC and prescription medications.

With respect to the transitional approach to covering habilitative services, we are very concerned that this policy will result in individuals not having access to needed therapy. For further discussion of our concerns, we direct you to our comments earlier in this letter under §156.110. To reiterate our recommendations, we urge HHS to require in the final rule that plans must meet the first option of covering habilitative services in parity with rehabilitative services if a state does not define them.

We applaud HHS for proposing in the rule that substitution of benefits across benefit categories would be prohibited. We also support the clarification that states have the authority to prohibit benefit substitution altogether or to enforce a stricter standard for substitution. However, we continue to be concerned that issuers would still be allowed to substitute benefits or sets of benefits that are actuarially equivalent within benefit categories. The EHB standard in the ACA is intended to ensure a consistent, minimum level of benefits across all non-grandfathered, fully-insured plans in the individual and small group insurance markets so that consumers can make an apples-to-apples comparison of plan options and to prevent insurers from adopting benefit designs intended to attract healthier people and deter enrollment by those in poorer health. The proposal to allow variation within benefit categories would undermine these goals.

§156.120 Prescription drug benefits

The proposed rule represents a significant improvement over the policy proposed in the EHB Bulletin with respect to the minimum level of coverage that would be required for prescription drugs. Instead of requiring issuers to cover just one drug in each category and class in which the EHB-benchmark plan covered at least one drug, a plan would have to cover ***at least the greater of*** one drug in each category and class ***or*** the same number of drugs in each category and class as the EHB-benchmark plan. After reviewing the EHB proposed benchmarks for all 50 states plus the District of Columbia, we found that the benchmarks for 45 states and DC cover at least 2 drugs in each of the 17 classes of cardiovascular drugs. For 5 states (CA, CO, MI, PA, and WI), however, their CVD drug coverage, while generally better than the original policy proposed in the Bulletin, does not meet the Medicare Part D standard of covering at least 2 drugs per class.

With respect to tobacco cessation drugs, however, the “fall back” option for drug classes not covered by the benchmark plan does not provide enough protection. In the proposed rule, HHS proposes that if a benchmark plan does not cover a class of drugs, the EHB requirement will be that other plans must cover at least one drug in that class. Under this proposal, many EHB standards for tobacco cessation medications would use this “fall back” option of only one drug. According to the benchmark plan information provided by HHS along with this proposed rule, 21 benchmark plans cover no drugs for tobacco cessation.

For these reasons, we encourage HHS to require that the EHB package cover at least 2 drugs per class. Our research suggests that most plans are already meeting this standard (at least with respect to CVD drugs) so this policy will not create an additional burden and cost for these plans. However, this policy will ensure that those plans falling short of this coverage provide this minimum level of coverage for their enrollees. We also encourage you to clarify that this coverage level is a floor and that additional drugs covered within a class would still be considered part of the EHB package.

We also generally support the proposal that drugs must be chemically distinct to count as separate drugs. However, we have a question about whether, under the proposed rule's definition of "chemically distinct" drugs, the five different nicotine-replacement-therapies (NRT) would be considered chemically distinct from one another? We strongly encourage HHS to not implement a policy that counts coverage of any number of NRTs as coverage of only one drug, particularly if the final rule also does not include a comprehensive definition of tobacco cessation benefits. While all NRTs contain nicotine, they use different mechanisms of bringing nicotine into the body. This difference in mechanisms is crucial when treating nicotine addicts with different levels of addiction. For instance, someone who is heavily addicted may need to use the nasal spray or inhaler, which delivers nicotine into the blood stream more quickly than the patch or gum. It is important that smokers wanting to quit have more than one NRT available to them, and treating NRTs as chemically the same will not guarantee this. If NRTs are chemically indistinct, then a benchmark plan covering all five available NRTs would only be counted as covering one – therefore allowing other EHB plans to cover only one.

Finally, we support the requirement that plans offering the EHB must have procedures in place to ensure that enrollees can obtain access to clinically appropriate drugs prescribed by a provider but not included on the plan's drug list. We encourage you to further spell out in the final rule what a plan's appeals process would be required to entail, including providing for an expedited determination for cases involving patients with serious health conditions.

§156.125 Prohibition on discrimination

As we mentioned earlier in our comments (under §156.110), we support the requirements that an issuer not discriminate in its benefit design, implementation of its benefit design, or marketing practices.

The prohibitions against discrimination will only be as good as their enforcement. The preamble of the rule says HHS intends to develop the framework for analysis tools to facilitate testing for discriminatory plan benefits but provides no further detail about what this will entail. While this sounds promising, we encourage you to include further detail in the final rule about your plans for monitoring and enforcing the non-discrimination provisions.

§156.130 Cost-sharing requirements

The proposed rule also codifies ACA's annual limitation on the amount of cost sharing that can be imposed on consumers. Cost sharing is defined to include deductibles, coinsurance, copayments, or similar payments, but excludes premiums, balance billing amounts, and spending for non-EHB services. We recognize that the definition is consistent with the statute, but we would have preferred a broader definition. Balance billing in particular is a serious and costly problem for patients, and it is particularly troubling when the consumer is in an emergency and can do nothing to avoid the charges. While we recognize that the 2010 patient protection rules take steps in the right direction to limit the amount that consumers can be charged for out-of-network emergency care, we would like to work with you to address balance billing concerns for other necessary and appropriate out-of-network medical care.

We are concerned that costs paid out-of-pocket for non-emergency benefits provided outside of a plan's network do not count towards the annual limitation on cost sharing. We believe these costs should count towards the annual limit, at the same amount as the plan would have paid had the benefits been provided in-network. This is often particularly important for children born with congenital heart disease who often require specialized interventions that are only available out-of-

network in a very few medical centers across the country. Accessing this care can greatly improve their chance of survival, but often their survival comes at a terrible financial cost to their parents. The preamble does note that states could require issuers to establish a maximum out-of-pocket limit that is applicable to out-of-network services, which is a helpful clarification.

We support the proposal to count out-of-pocket spending for out-of-network emergency services towards the annual limitation on cost-sharing. Our understanding is that any amount paid by the enrollee for out-of-network emergency services already counts towards the patient's annual deductible, but if not, this should also be the case. This policy acknowledges that consumers often have little or no control in emergency situations, such as a heart attack, stroke, or cardiac arrest, and patients should not be penalized for using out-of-network services involuntarily. They purchase insurance to guard against the risks of unforeseen illnesses and insurance does not do its job when it leaves consumers unprotected against emergencies.

Finally, we support the provision of the rule that codifies the ACA requirement that annual deductibles do not apply to preventive care.

§156.135 AV calculation for determining level of coverage

The proposed rule invites comments on the methodology for the development of the AV calculator. In general, we support the calculator approach because it will help to ensure the consistent calculation of AV across issuers. We are also comfortable that the underlying claims dataset being used is sufficiently robust to accurately reflect use of services by a standard population. However, we are concerned that the use of continuance tables, as opposed to microsimulation, represents an enormous missed opportunity to model the complex benefit designs and cost-sharing features that are found in most health plans today. As a very helpful report from Consumers Union points out, "The ratebook approach can work very well if the plan design is simple, but it is less precise and requires more judgment when the design is complicated."[3] For instance, with the continuance tables as proposed by HHS, the AV calculator will not be able to accommodate per service limits that are common in plans today. For example, our review of the proposed state EHB benchmark plans found that many of them impose number of visit limits on services such as mental health and outpatient therapy services. Continuance tables also do not capture differences in cost-sharing that result from value-based insurance design or wellness programs. Microsimulation models, on the other hand, can account for these complexities. To quote again from the Consumers Union report: "As long as both charge and service use detail is included in the underlying data, a wide variety of plan provisions can be accommodated (by microsimulation). If emergency room visits and specialty care visits have unique copayments rather than coinsurance (for example), the impact of these provisions on overall plan payments can be estimated directly, rather than relying on actuarial judgment." In sum, use of microsimulation would help assure greater consistency in the AV calculations across plans and ensure that much fewer plans would have to use the alternatives for calculating AV that are proposed under the rule.

If the continuance tables are to be used, we are concerned that the proposed tables seem to assume changes in consumer demand associated with different cost-sharing levels. While we acknowledge that differences in cost-sharing do affect consumers' use of health care services, including these assumptions in the tables obscures real differences between plans and their cost-sharing features. (That is, two plans with identical cost-sharing features would receive different AV calculations, depending on which metal tier's continuance table was used.) This does a disservice

[3] McDevitt R and Lore R. Actuarial Value under the Affordable Care Act: Plan Valuation with the Consumer in Mind. June 8, 2012. Accessed online at: http://www.consumersunion.org/pdf/Plan_Valuation_with_the_Consumer_in_Mind.pdf.

to consumers seeking to make apples-to-apples comparisons of health plans' AV. It also adds an unnecessary level of complexity to the calculator.

§156.140 Levels of coverage

The proposed rule would allow a *de minimis* variation of +/- 2 percent for AV for all non-grandfathered plans. There are sound reasons for allowing some variation. For instance, it would allow insurers to offer plans with "round numbers" and allow cost-sharing levels to remain the same over several years. However, any plan with an AV under 70% should be excluded when determining the second lowest cost Silver Plan for purposes of calculating the premium tax credit.

§156.275 Accreditation of QHP Issuers

The rule proposes allowing additional accrediting entities, in addition to those entities which have already been recognized as accrediting entities, to apply for phase one recognition. We support this proposal to provide greater choice and competition among accrediting entities, provided that as the rule would require, any new entities can demonstrate that they have standards that are at least as strong as those of the already approved national accreditation entities and meet all of the requirements for such organizations laid out in Section 1311(c)(1)(D)(i) of the ACA. A driving principle should be assuring that, regardless of which entity a plan is accredited by, consumers are able to use accreditation information to make meaningful, apples-to-apples comparisons of QHPs. We also appreciate that the process for recognizing additional accrediting entities will be transparent, including an opportunity for public comment. In order to be able to comment effectively, we urge the Department to make the documentation required to be included in the application, including the crosswalk that shows how the accrediting entity meets the standards of the regulation, publicly available.

We also recommend that accreditation information be presented to consumers in a way that appropriately describes how the QHP Issuer was reviewed. In particular, the exchanges should display whether a QHP Issuer is accredited and by which accreditor and note whether the issuer's exchange plan is accredited.

Finally, the Department has indicated in previous rules and guidance that it plans to eventually replace this interim phase one accrediting process with a second phase. We strongly support this decision and, as noted previously, encourage the Department to clearly indicate when phase two is expected to begin. We believe the standards for recognition can and should be used to help move us closer to a high value, patient-centered health care system rather than to reinforce the status quo. However, for this to happen, the Department will need to clearly outline these standards with sufficient advance notice for current and potential accrediting entities to make any necessary updates to their programs. In particular, we encourage the Department to require that accrediting entities review a number of health plan processes important to consumers, including but not limited to those related to marketing practices, member privacy, and language access services. In addition, accrediting entities should assess health plan efforts to reduce health care disparities and provide culturally competent services. As part of phase two, there should also be a process for the Department to regularly update its accreditation standards over time, especially as delivery and payment system reforms catalyzed by the ACA begin to take root and new ways of measuring health care quality and patient experience are developed.

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Thank you again for the opportunity to share our comments on these issues related to essential health benefits, the actuarial value of qualified health plans, and the accreditation of QHPs. If you have any questions, please feel free to contact Stephanie Mohl, Government Relations Manager, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

Donna K. Arnett, PhD, BSN, FAHA
President