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VIA ELECTRONIC SUBMISSION TO www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

To Whom It May Concern:

Cigna welcomes the opportunity to respond to the Notice of Benefit and Payment Parameters for 2024 proposed rule issued by the Department of Health and Human Services (HHS) ("the proposed rule"). Cigna appreciates HHS' efforts to increase access to health care services, simplify choice and improve the plan selection process, and make it easier to enroll in coverage. We raise serious concerns with the concurrent implementation of provisions that will be disruptive and confusing to consumers and difficult for issuers to implement simultaneously, and we urge HHS to consider an implementation plan that prioritizes the consumer experience.

Cigna Corporation is a global health services organization dedicated to improving the health, well-being, and peace of mind of those we serve. Our subsidiaries are major providers of medical, pharmacy, dental, and related products and services, with over 185 million customer relationships in the more than 30 countries and jurisdictions in which we operate. Within the United States, Cigna provides medical coverage to approximately 14 million Americans in the commercial group health plan market, predominantly in the self-insured segment. For 2023, we will be providing coverage in the individual Affordable Care Act insurance segment in sixteen states, both on- and off-Exchange, to more than 743,000 people. Additionally, we serve approximately 4.3 million people through our Medicare Advantage, Medicare Prescription Drug Program and Medicare Supplemental products. In all of the segments we serve, Cigna is focused on working to deliver health care that is affordable, predictable, and simple – so people can live healthier, more vibrant lives.

We support HHS' goals of simplifying choice and making enrollment easier for consumers. However, we strongly urge HHS to reconsider the impact on consumers if HHS finalizes its rulemaking for 2024 as proposed. Our comments raise concerns with proposals that will reduce consumer choice by limiting

innovative product offerings, including proposals to limit the number of non-standardized plan options and the number of prescription drug tiers. We urge HHS to maintain issuer flexibility to meet diverse consumer needs. We also raise concerns with the proposal to permit Exchanges the option to offer earlier coverage effective dates for qualified individuals losing other minimum essential coverage (MEC) and propose mid-month enrollment as an alternative. We strongly oppose HHS' proposal to permit a special enrollment period (SEP) for consumers affected by a change in their plan's provider network, as changes in provider networks often happen with little notice to issuers and consumers are protected from disruption through existing continuity of care provisions. We request HHS delay the proposed network adequacy standards to provide an additional year for issuers and regulators to address outstanding process and contracting challenges before layering on new and burdensome requirements for issuers and providers.

In addition, many of the proposals would be significantly disruptive to consumers and create confusion in the marketplace if implemented at the same time. Issuers would also be greatly challenged to meet implementation for 2024, if the final proposed rule is issued in April 2023. We recommend HHS delay the effective dates of the following provisions: non-standardized plan limits; plan and plan variation marketing name requirements; annual eligibility redeterminations; prescription drug tiers for standardized plans; and network adequacy in order to provide issuers adequate implementation time and clarifying guidance, if needed. Specifically, we request HHS first implement non-standardized plan limits and plan variation marketing name requirements in order to solidify plan naming and portfolio development, followed by modifying the re-enrollment hierarchy for annual eligibility redeterminations. Addressing plan limits and naming conventions prior to mapping customers into new plans will ensure that consumers are minimally disrupted by and understand the impact of the proposed changes.

With that context as background, Cigna offers the following comments on the proposed rule.

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III. Provisions of the Proposed Regulations
A. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment
2. HHS Risk Adjustment (§ 153.320)
a. Data for Risk Adjustment Model Recalibration for 2024 Benefit Year
HHS proposes to use 2018, 2019, and 2020 benefit year enrollee-level External Data Gathering Environment (EDGE) data to recalibrate the 2024 benefit year risk adjustment models with a narrowly tailored exception to exclude the 2020 benefit year data from the blending of the age-sex coefficients for the adult models (Option 4 of the alternative approaches). HHS is concerned that not making any adjustments with respect to the use of 2020 enrollee-level EDGE recalibration data could have an undue impact on the risk captured by the age-sex factors in the adult models such that these factors would less accurately reflect the expected spending patterns for the 2024 benefit year. HHS requests comment on its proposal.

Of the six alternative approaches HHS proposes, Cigna prefers Option 5, which would exclude the 2020 benefit year enrollee-level EDGE recalibration data and instead use the 2017, 2018, and 2019 benefit year enrollee-level EDGE recalibration data, trended forward to the 2024 benefit year, in recalibration of the risk adjustment models for the 2024 benefit year, or use the final 2023 risk adjustment model coefficients for the 2024 benefit year without trending the data to account for inflation and changes in costs and utilization between the 2023 and 2024 benefit years. We would prefer HHS make accommodations for "anomalous decreases in unconstrained coefficients" rather than set a precedent of deleting coefficients to

address data anomalies. While HHS found that the 2019 and 2020 benefit year enrollee-level EDGE data were somewhat comparable, noted increases in telehealth claims, the increase in frequency of Hierarchical Condition Category (HCC) 127, and the "likely decrease in discretionary spending" found in 2020 are indicators of an outlier year whose data attributes are likely not repeated in subsequent years, potentially creating distortions in the model.

c. Request for Information: Payment HCC for Gender Dysphoria
HHS requests information on adding a payment HCC for gender dysphoria to the HHS-operated risk adjustment models for future benefit years. HHS determined that a new payment HCC for gender dysphoria would satisfy some but not all of the 10 Principles of HHS-Operated Risk Adjustment.

Cigna agrees with the proposal to add a payment HCC for gender dysphoria in future models as it meets the criteria of being clinically meaningful and predictive of medical and drug expenditures. HHS should consider interactions between gender dysphoria and behavioral and mental health diagnoses, as well as hormone therapy and associated surgeries. International Classification of Diseases (ICD) diagnosis code descriptors should account for the incongruence between gender and clinical diagnoses. However, we recommend a broader range of diagnosis options within ICD-10. We encourage HHS to work with stakeholders to determine how best to incorporate gender dysphoria into the risk adjustment model and provide necessary education to ensure that any related diagnoses are coded appropriately.

e. CSR Adjustments
We request HHS evaluate the effectiveness of the risk adjustment formula with respect to cost-sharing reduction (CSR) variants and enrollment duration factors (EDFs) for special enrollment customers. Within the risk adjustment formula, current factors, specifically when applied to CSR 87 and 94 plans, do not accurately reflect population risk. Additionally, the EDFs within the formula do not fully capture the financial impact of duration for consumers who enroll during special enrollment periods. We request HHS further investigate how the risk adjustment model can be updated and improved to reflect more recent changes to enrollment periods and profiles to maintain stability and choice in the market.

4. Repeal of Risk Adjustment State Flexibility to Request a Reduction in Risk Adjustment State Transfers (§ 153.320(d))
HHS proposes to repeal the flexibility under § 153.320(d) for States to request reductions of risk adjustment State transfers under the State payment transfer formula in all State market risk pools, including those prior participant States that previously requested a reduction, for the 2025 benefit year and beyond.

Cigna is supportive of HHS' proposal, as it would reduce potential uncertainty and volatility.

5. Risk Adjustment Issuer Data Requirements (§§ 153.610, 153.700, and 153.710)
a. Collection and extraction of the QSEHRA indicator
HHS proposes that issuers would be required to collect and submit a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) indicator as part of the required risk adjustment data that issuers make accessible to HHS from their respective EDGE servers in States where HHS operates the risk adjustment program, beginning with the 2023 benefit year. HHS proposes to generally permit issuers to populate the required QSEHRA indicator with information from the FFE or SBE-FP enrollees or enrollees through SBEs, or from other sources for collecting this information. HHS is also proposing a transitional approach for the collection and extraction of the

QSEHRA indicator. For the 2023 and 2024 benefit years, issuers would be required to populate the QSEHRA indicator using only data they already collect or have accessible regarding their enrollees. Beginning with the 2025 benefit year, HHS proposes that issuers would be required to populate the QSEHRA field using available sources and, in the absence of an existing source for particular enrollees, to make a good faith effort to ensure collection and submission of the QSEHRA indictor for these enrollees.

Cigna has concerns with the proposal to require issuers to collect and submit a QSEHRA indicator as this data element is not readily available, difficult to collect, not necessary for risk adjustment purposes, and affects a small population of enrollees. We agree with HHS that the information to populate the QSEHRA indicator is not routinely collected by all issuers at this time and poses administrative burden for issuers in developing processes for collection, validation, and submission of this new data element. We appreciate HHS' proposal of a transitional approach for the collection and extraction of the QSEHRA indicator to allow sufficient implementation time.

However, we expect issuers will face challenges developing collection and validation processes for the QSEHRA indicator. Issuers would likely have to reach out to consumers for additional information outside of the enrollment process, assuming they are knowledgeable about whether their plan is a QSEHRA. As such, HHS should consider alternative methods of extracting this data, such as from employers that sponsor QSEHRA plans or from the Exchanges during enrollment.

7. Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS-RADV) (§§ 153.350 and 153.630)
c. Discontinue Lifelong Permanent Conditions List and Use of Non-EDGE Claims in HHSRADV
HHS seeks comment on discontinuing the use of the Lifelong Permanent Conditions (LLPC) list and the use of non-EDGE claims starting with the 2022 benefit year of HHS-RADV. HHS also seeks comments on discontinuing the current policy that permits the use of non-EDGE claims in HHS-RADV beginning with the 2022 HHS-RADV benefit year.

Cigna opposes the proposal to discontinue the LLPC list and the use of non-EDGE claims. An approved, recognized list of chronic, life-long conditions creates standardization and regularity in risk adjustment coding of impactful diagnoses, allowing for the capture of status codes to contribute to an accurate health acuity picture of the enrollee. Additionally, issuer diagnostic data can be impacted by partial year enrollment or calendar year documentation. The LLPC list supports the ability of issuers to capture chronic conditions which may be initially diagnosed in a previous period, and for which the issuer is covering treatment costs. We recommend HHS continue the LLPC list and codify how it applies to EDGE rules.

Regarding the proposal to discontinue the use of non-EDGE claims, claims data on EDGE is often incomplete, due to the nature of claims adjudication processes. Therefore, non-EDGE claims are a permitted remedy to allow for thorough audit data submission and capture of accurate conditions for the sampled enrollees affected. Additionally, the inconsistent nature of chart retrieval may not yield the medical records associated with EDGE claims. This would necessitate the usage of the non-EDGE claims rule within the audit for submission of a medical record associated with a claim that meets criteria but missed the deadline. We recommend HHS continue the use of non-EDGE claims.

d. HHS-RADV Discrepancy and Administrative Appeals Process
HHS proposes to shorten the window to confirm the findings of the second validation audit (SVA) (if applicable), or file a discrepancy report, to within 15 calendar days of the notification by HHS, beginning with the 2022 benefit year of HHS-RADV. Issuers currently have 30 calendar days to confirm the findings of the SVA, or file a discrepancy report, to dispute those SVA findings.

Cigna opposes the proposal to shorten the window to confirm the findings of the SVA or file a discrepancy report. Issuers need sufficient timing to complete and file discrepancy reports. Shortening the window of time would limit the ability for issuers to prepare an appropriate response. We request HHS keep the current window of 30 calendar days.

B. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act
6. Annual Eligibility Redetermination (§ 155.335)
HHS proposes to allow Exchanges to modify their re-enrollment hierarchies such that enrollees who are eligible for cost-sharing reductions (CSRs) and who would otherwise be automatically re-enrolled in a bronze-level Qualified Health Plan (QHP) without CSRs, to instead be automatically re-enrolled in a silver-level QHP in the same product with a lower or equivalent premium. HHS proposes to allow all Exchanges to ensure enrollees whose QHPs are no longer available to them and enrollees who would be re-enrolled into a silver-level QHP in order to receive income-based CSRs are reenrolled into plans with the most similar network to the plan they had in the previous year. HHS proposes that Exchanges would implement this option beginning with the open enrollment period for plan year 2024 coverage, if operationally feasible, and if not then beginning with the open enrollment period for plan year 2025 coverage.

Cigna supports HHS' goal of ensuring that consumers understand and consider the most cost-effective plan options. However, we strongly oppose HHS' proposal to allow Exchanges to modify their re-enrollment hierarchies for 2024 as it would harm consumer choice and cause unnecessary abrasion and confusion. It would also not be operationally feasible to implement the proposed changes in the proposed timeframe.

Consumers actively choose their health plans for several reasons, including but not limited to net premium, provider network, and out-of-pocket costs. While some consumers may prioritize net premium over other considerations, others may choose a plan based on a specific carrier, provider network, and cost-sharing arrangements, or based on their ability to enroll in a high deductible health plan or HSA. This proposal assumes consumers value income-based CSRs and net premium above all other factors – and while this may be true for some consumers, it is incorrect to assume this applies to all consumers, especially those who actively select a plan that supports their own, unique health conditions.

We also request HHS consider the sequential implementation order that is most optimal and least disruptive to consumers, rather than implementing multiple provisions concurrently, as that will be extremely disruptive and confusing to consumers. Re-enrollment hierarchies should remain stable until requirements on non-standardized plan limits are finalized and issuers have finalized their product decisions in accordance with those requirements. We also propose later in our comments that plan and plan variation marketing names should first be accurate, consistent, and understood by consumers before consumers are mapped into new plans they are unfamiliar with. Finally, we have significant concerns with the timing of renewal notifications to members. Existing requirements around renewal notices could cause mass consumer confusion if consumers receive two separate renewal notices with different

information about their health plan selection. Under current processes, consumers would likely receive one notice from their issuer prior to the re-enrollment process, informing them of continued enrollment in their selected bronze plan, and a second notice from the Exchange advising them that they will be re-enrolled into a silver plan. HHS should update its processes to allow for more timely notification of mapping data to issuers to avoid multiple, confusing notices to consumers.

Furthermore, we continue to believe the consumer should be in charge of the selection of their plan. Consumers who are auto-enrolled into a plan they did not actively select may end up confused, frustrated, and have difficulty understanding their new plan benefits. To preserve consumer choice, HHS could alert the consumer to the availability of a lower cost plan and enhance the consumer shopping experience and decision support tools to improve customer understanding, but the decision to switch plans should rest with the consumer. Consumers select plans for various reasons, and those considerations may not be contemplated in the proposed reenrollment hierarchy, generating confusion and frustration for consumers.

7. Special Enrollment Periods (§ 155.420)
b. Effective Dates for Qualified Individuals Losing Other Minimum Essential Coverage (§ 155.420(b))
HHS proposes to permit Exchanges the option to offer earlier coverage effective start dates for consumers attesting to a future loss of MEC, to mitigate coverage gaps when consumers lose forms of MEC mid-month and allow for more seamless transitions.

We appreciate HHS' decision not to propose retroactive coverage effective dates for consumers reporting past loss of MEC and instead limit these proposed changes to future loss of MEC to avoid adverse selection and reduce burden on Exchanges, States, and issuers. However, we would prefer HHS permit Exchanges the option to offer mid-month coverage effective dates for consumers who lose MEC mid-month. We would also support limiting the mid-month enrollment flexibility to the states where Medicaid or CHIP is regularly terminated mid-month.

Additional Comments Requested
HHS seeks comment on whether QHP consumers whose providers leave their network mid-year or otherwise experience a significant change in their plan's provider network should be eligible for an SEP. HHS also seeks comment on whether it should consider an enrollee who is impacted by a provider contract termination to be someone who is experiencing an exceptional circumstance or should be eligible for a new SEP and what standards would serve as a basis for SEP eligibility.

We strongly oppose HHS' proposal to permit an SEP for QHP consumers affected by a significant change in their plan's provider network. Changes in provider networks happen frequently and often with little notice to issuers. Despite these challenges, issuers are prepared to respond to network disruptions to ensure consumers have consistent access to high-quality providers and facilities. Network disruptions do not change the value of the health plan, as issuers adapt their networks to changing circumstances. Furthermore, existing QHP and No Surprises Act continuity of care provisions protect consumers from disruptions in care by requiring notice of network changes and permitting enrollees to continue care with out-of-network providers under certain circumstances.

Additionally, there is no clear definition or standard of what would constitute a "significant network change," which would make this proposal very challenging to operationalize. If HHS finalizes this provision as proposed, we recommend HHS apply a very clear standard of what would constitute a "significant network change."

C. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

3. Standardized Plan Options (§ 156.201)

HHS proposes to continue to use four tiers of prescription drug cost sharing in the proposed standardized plan options: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. All covered generic drugs must be placed in the generic drug cost-sharing tier, or the specialty drug tier if there is an appropriate and non-discriminatory basis for doing so, and all brand name drugs must be placed in either the preferred or non-preferred brand tier, or specialty drug tier if there is an appropriate and non-discriminatory basis for doing so. HHS believes the use of four tiers of prescription drug cost-sharing will continue to allow for predictable and understandable drug coverage. HHS requests comment on its proposed approach to standardized plan options for PY 2024 and on the appropriate number of drug tiers to use in standardized plan options in the future.

Cigna strongly opposes the prescription drug tiering proposals and requests HHS retain issuers' ability to have varied prescription drug tiering. Issuers design prescription drug tiers based on clinical standards to maximize efficacy, quality, and affordability for enrollees and they are often standard across multiple plan types. As pharmaceutical innovation has progressed, the traditional viewpoint that generic drugs are the lowest-cost or highest value option is not always the case. HHS' proposed changes to drug tiering in standardized plans would not account for high-cost generic drugs or scenarios where high-priced brand drugs are able to be placed onto a lower-cost tier. This proposal would also incentivize manufacturers to raise the cost of certain drugs and encourage them to take advantage of mandatory tier placement. Together, these impacts will ultimately increase prescription drugs costs and increase premiums for consumers.

Additionally, we continue to urge HHS to allow issuers the flexibility to develop formulary drug tiers in the manner they determine is most effective in promoting prescription drug affordability, rather than limiting them to four tiers. We support the flexibility to offer five or six drug tiers to develop cost-effective formulary plan designs and provide value to consumers.

If HHS finalizes this provision as proposed, issuers will need more implementation time to develop new formularies and get those formularies approved by Pharmacy and Therapeutics Committees and ready for plan filing. As such, we request HHS consider delaying this provision to 2025 to allow sufficient time to operationalize the proposed changes.

4. Non-Standardized Plan Option Limits (§ 156.202)

HHS proposes to limit the number of non-standardized plan options that issuers of QHPs can offer through Exchanges to two non-standardized plan options per product network type and metal level, in any service area, for PY 2024 and beyond. HHS proposes to apply a meaningful difference standard as an alternative to limiting the number of non-standardized plan options. HHS proposes grouping plans by issuer ID, county, metal level, product network type, and deductible integration type, and evaluating whether plans within each group are "meaningfully different" based on differences in deductible amounts. HHS seeks comment on the feasibility and utility of limiting the number of non-standardized plan options, if a stricter or more relaxed limit should be adopted, and if the limits should be phased in. HHS also seeks comment on imposing a new meaningful difference standard in place of limiting the number of non-standardized plan options that issuers can offer,

and whether additional or alternative specific criteria should be included, including the specific deductible dollar difference threshold.

We acknowledge HHS' concern that consumers in some markets have a significant number of plan choices that can be difficult to meaningfully differentiate. However, limiting non-standardized plan options as a way to mitigate choice overload will adversely impact consumers by harming competition, disrupting coverage for existing enrollees, and stifling value-based insurance designs. We urge HHS to reconsider its proposal and allow issuers more flexibility to meet consumer needs with a diverse range of plan offerings. We recommend HHS consider a limit of up to five non-standardized plan options per product network type and metal level, with no reduction in the limit in future years.

We also request sufficient implementation time in order to make the necessary operational changes, as issuers would be well underway with plan filings when the final Notice of Benefit and Payment Parameters for 2024 is expected to be issued and strategic decisions about plan offerings and participation have already been made. Finalizing these changes for the 2024 plan year would result in significant operational challenges and rework, jeopardizing the ability for issuers to continue offering coverage in existing service areas. We reiterate our earlier concerns that HHS is proposing the concurrent implementation of multiple provisions that will be extremely disruptive and confusing to consumers. HHS should finalize requirements on non-standardized plan limits first before finalizing re-enrollment hierarchy modifications.

Cigna would be supportive of the proposed meaningful difference standard as an alternative to limiting non-standardized plan options, provided it was broadened beyond the $1,000 deductible criteria to include other factors such as provider networks, plan design, cost-sharing, HSA eligibility, and other features. The proposed $1,000 deductible difference threshold for plans is too high to be consumer-friendly: we recommend a $500 standard to incorporate additional flexibility and options for consumers with varied budgets and preferences. Consumers shop for plans with a number of different priorities in mind, and only differentiating plans based on deductible does not adequately account for these important plan differences. We would support the consideration of more criteria in the meaningful difference standard and a lower deductible difference threshold.

Finally, to achieve HHS' goal of reducing consumer choice overload, we recommend HHS improve decision-making tools on healthcare.gov to reduce consumer confusion during the plan selection process and allow better filtering of plan options and descriptions of plan features. An improved decision support tool that accurately accesses a consumer's health care utilization could help enrollees focus their plan choices to those that best fit their needs.

6. Plan and Plan Variation Marketing Name Requirements for QHPs (§ 156.225)
HHS proposes to require that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. HHS would review plan and plan variation marketing names during the annual QHP certification process in close collaboration with State regulators in States with Exchanges on the Federal platform. HHS seeks comment on this proposal and whether there are additional methods of preventing consumer confusion and market disruption related to this issue, including a required format for plan and plan variation marketing names that specifies elements such as name of issuer, metal level, and limited cost-sharing information.

We agree with HHS that consumers applying for coverage should be able to understand references to benefit information in plan and plan variation marketing names, and they should be able to confirm any information from the plan name in the plan's publicly available benefit descriptions. We urge HHS to include the use of generic level names like "elite" or "premium" in its reviews of plan and plan variation marketing names, in addition to the use of cost-sharing information, unspecified dollar amounts, covered benefit discrepancies, and HSA references.

In addition, the proposed policy would require all information included in plan and plan variation marketing names that relates to plan attributes to correspond to and match information that issuers submit for the plan in the Plans & Benefits Template. However, the Plans & Benefits Template has limitations, as it does not capture key benefits and details that consumers may be searching for during the plan selection process. For example, the template currently does not capture benefits such as virtual care or benefits aimed at addressing social determinants of health, such as free transportation. As such, we recommend against adopting strict implementation standards, specifically those that require all information related to plan attributes to correspond in materials submitted as part of the QHP certification process since some of these materials have limitations and do not adequately capture all of a plan's benefits.

Furthermore, several states already regulate plan marketing names and have detailed requirements regarding what plans can and cannot include in their marketing names. We urge HHS to defer to states with adequate marketing standards, rather than adopting duplicative requirements in those states.

Issuers work to ensure that consumers have the necessary tools to make informed decisions when selecting a health insurance plan by appropriately detailing plan benefit design, cost-sharing requirements, and other features in the plan details page on healthcare.gov. However, these details are not always displayed in a clear manner on healthcare.gov and could be refined to ensure that consumers can understand the different innovative features that differentiate plans from one another without having to include these features in the plan name.

We strongly urge HHS to delay this provision to 2025 to prevent consumer confusion and market disruption. Issuers would be well underway with plan filings when the final Notice of Benefit and Payment Parameters for 2024 is expected to be issued. As HHS notes, the plan or plan variation marketing name is used in multiple materials developed and distributed through different operational areas at each issuer. Issuers would benefit from additional implementation time and more specific guidance from HHS on permitted naming practices in order to prevent rework of consumer materials. In addition to requesting an implementation delay, we suggest to HHS that this proposal be implemented first, followed by the proposed changes to the re-enrollment hierarchy. This will ensure that plan and plan variation marketing names are first accurate, consistent, and understood by consumers, before consumers are mapped into new plans they are unfamiliar with.

7. Plans that Do Not Use a Provider Network: Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

Compliance with Appointment Wait Time Standards

For the 2024 plan year, HHS proposes to evaluate QHPs for compliance with network adequacy standards based on time and distance standards and appointment wait time standards via attestation. Issuers must work with their network providers to collect the necessary data to assess appointment wait times and determine if their provider network meets the wait time standards

detailed in the 2023 Letter to Issuers, as HHS will begin conducting such reviews of issuer attestations for PY 2024.

We request HHS revisit network adequacy standards and delay their implementation until 2025 to provide a more valuable consumer experience. Over the past year, issuers worked in partnership with HHS to revise their networks to meet new federal time and distance standards. Issuers have faced several challenges throughout implementation, including provider shortages, contracting challenges, complying with new template formats, and adapting to new processes and timelines. We strongly recommend HHS provide an additional year for issuers and regulators to address outstanding issues related to the time and distance requirements and refine the new network adequacy review process before layering on new, complex, and burdensome requirements for issuers and providers. We welcome the opportunity to partner with HHS to conduct evidence-based issuer testing for appointment wait time standards and build a reasonable framework for assessing appointment availability to ensure that both parties have the right tools to operationalize the new requirements in the most efficient way possible. There are many outstanding details regarding the assessment and attestation of appointment wait times that will require definition, testing, and refinement before implementation. We also recommend HHS consider how to best engage providers in this process to decrease the overall burden on providers and payers and encourage provider participation. Rushed implementation is likely to add confusion and costs, especially as issuers continue to implement time and distance standards.

We recommend that HHS establish clear timelines for the review process. Advance notice of HHS timing and anticipating feedback would improve communication and understanding of expectations and allow issuers to respond in a timely way. We ask HHS to consider identifying a deadline to notify issuers whether their plan has been approved under the process and to publish network adequacy templates as soon as possible to allow plans adequate time for submission and include options for drop down menus and inclusion of additional documentation. Second, we ask HHS to utilize the exceptions process to time and distance standards when it is in the best interest of consumers and clearly communicate these instances to issuers. For example, provider shortages, rural access issues, or significant geographic barriers are considerations that should be granted exceptions to preserve access, as appropriate. Additionally, lack of consumer complaints and state regulator feedback could help inform HHS when granting exceptions is appropriate.

8. Essential Community Providers (§ 156.235)
HHS proposes to establish two additional stand-alone Essential Community Providers (ECP) categories for Mental Health Facilities and Substance Use Disorder (SUD) Treatment Centers. HHS also proposes to add Rural Emergency Hospitals as a provider type in the Other ECP Providers category. QHPs must satisfy a 35 percent threshold for Federally Qualified Health Centers and Family Planning Providers in addition to the overall 35 percent ECP threshold requirement in the plan's service area. HHS anticipates that any QHP issuers falling short of the 35 percent threshold for PY 2024 and beyond could satisfy the standard by using ECP write-ins and justifications.

We appreciate HHS' acknowledgement of provider shortage challenges and the uneven distribution of SUD Treatment Centers and Mental Health Facilities. However, we raise concerns with this proposal. We recommend HHS maintain the current overall ECP threshold of 35 percent of available ECPs in a plan's service area, rather than adding the 35 percent threshold to two new categories for 2024. Moving from a threshold across all categories to requiring a threshold for specific categories limits issuer flexibility to account for variables such as provider shortages and distribution, enrollee population distribution, and rural access, and will make it more difficult for issuers to meet these thresholds. Setting additional

minimum thresholds further burdens providers and issuers, which will now be required to submit additional ECP write-ins and justifications.

Furthermore, we urge HHS to consider provider outreach attempts as sufficient in fulfilling ECP standards. Issuers encountered many challenges throughout the 2023 QHP certification process that made it difficult to finalize contracts with high-quality providers, including unresponsive providers, providers not contracting in good faith, and difficult decisions to contract with low-quality providers who otherwise would not meet their network standards in order to fill network gaps. If this policy is finalized, issuers could be forced to offer contracts to low-quality providers in situations where high-quality providers are unresponsive to issuer outreach attempts.

10. Final deadline for reporting enrollment and payment inaccuracies discovered after the initial 90-day reporting window (§ 156.1210(c))
HHS proposes to remove the alternate deadline that allows an issuer to describe all data inaccuracies identified in a payment and collection report by the date HHS notifies issuers that the HHS audit process with respect to the plan year to which such inaccuracy relates has been completed, in order for these data inaccuracies to be eligible for resolution.

Cigna supports this proposal.

Conclusion

Thank you for your consideration of these comments.

Cigna would welcome the opportunity to discuss these issues with you in more detail at your convenience.

Respectfully,

Kristin Julason Damato