January 23, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P, P.O. Box 8016
Baltimore, MD 21244-8016

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services

RE: RIN 0938-AU65; CMS-9911-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

Dear Administrator Brooks-LaSure and Director Montz:

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 7,000 physicians and associated health professionals who specialize in the prevention and treatment of addiction, thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 (hereinafter, "NBPP 2023 Rule").

ASAM commends you for your commitment to addressing the pervasive health inequities in America, which have been exposed and exacerbated by the COVID-19 pandemic. One area of persistent and worsening inequity in American health care relates to addiction medicine access. Drug overdose death rates have now reached historic highs. Estimates for drug overdose deaths exceed 100,000 for the 12-month period to June 2021,[1] with overdose death rates rising among Black and Hispanic Americans.[2] Alcohol consumption, generally, is also on the rise.[3]

These increases in substance use and overdose deaths certainly reflect a combination of treatment disruptions, social isolation, and other hardships imposed by the pandemic, but they also reflect the

longstanding inadequate financing of our addiction treatment infrastructure. Even before the pandemic began, in 2019, more than 21 million Americans aged 12 or over needed treatment for a substance use disorder (SUD), but only about 4.2 million Americans received any form of treatment for it.[4] According to the most recent National Survey on Drug Use and Health, a startling 40.3 million people aged 12 or older had a SUD in the past year, including 28.3 million with alcohol use disorder, 18.4 million with an illicit drug use disorder, and 6.5 million with both alcohol use disorder and an illicit drug use disorder.[5]

In light of this nation's persistent addiction and overdose crisis, ASAM offers the following comments on the provisions of the NBPP 2023 Rule:

Guaranteed Availability of Coverage: Past-Due Premiums

Under current interpretation of the Affordable Care Act (ACA)'s guaranteed availability requirement, to the extent permitted by applicable state law, an issuer does not violate the ACA's guaranteed availability requirements when the issuer attributes a premium payment made for new coverage to any past-due premiums owed for coverage from the same issuer or another issuer in the same controlled group within the prior 12-month period before effectuating enrollment in the new coverage. The **NBPP 2023 Rule reinterprets the guaranteed availability requirement** at section 2702 of the Public Health Service Act (and its implementing regulation at § 147.104) **in a way that would require issuers to accept individuals who apply for coverage, even when the individual owes past-due premiums. ASAM supports such proposed reinterpretation of the ACA's guaranteed availability requirement**.

Denying coverage because of past-due premiums disproportionately hurts individuals with addiction who may have low incomes or who may otherwise be experiencing economic hardship. Requiring such individuals to pay back past-due premium plus a binder payment prior to enrollment may present an insurmountable barrier leading to gaps in addiction care coverage. Further, risk that some enrollees may take advantage of any reinterpretation of guaranteed availability rules is mitigated by the fact that issuers may pursue other mechanisms to collect past-due premiums. The ongoing and devastating impact of the COVID-19 pandemic, as well as the nation's ongoing addiction and overdose crisis, makes such a reinterpretation critical. ASAM is supportive.

Nondiscrimination on the Basis of Sexual Orientation and Gender Identity

While the United States Department of Health and Human Services (HHS) previously codified explicit nondiscrimination protections based on sexual orientation and gender in certain ACA-related regulations, amendments made in 2020 removed previous references to sexual orientation and gender identity. **If finalized, the NBPP 2023 Rule would revert to pre-2020 nondiscrimination protections. ASAM supports the proposal to prohibit certain exchanges, insurers, and agents and brokers from discriminating based on sexual orientation and gender identity.**

People who identify as part of the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community face pervasive health and health care disparities, and are at higher risk for many concomitant conditions, including SUD.[6] Further, it is well-established that they also face discrimination when seeking health care, resulting in poorer health outcomes than their straight

and cisgender peers. For example, one study found that 56% of LGB people reported experiencing discrimination from health care providers – including outright refusals of care– because of their sexual orientation.[7] According to another survey, 8% of surveyed LGBQ people and 29% of transgender people had been refused health care because of their identity.[8] The proposal to revert to pre-2020 nondiscrimination protections is consist with ASAM's commitment to advancing health equity and ensuring that full-spectrum addiction care is accessible to all.

Refine Essential Health Benefit (EHB) Nondiscrimination Policy for Health Plan Designs (§ 156.125)

Prior to the ACA, health insurers could discriminate against people with pre-existing conditions, including persons with addiction, by charging them higher premiums, excluding coverage, or refusing to provide coverage altogether. Although the ACA made certain practices unlawful for issuers required to provide essential health benefits (EHB), some may still discriminate through other mechanisms. For example, even for those patients with insurance policies that cover addiction treatment services, access to needed care may be compromised by acute-care model benefit design.[9] This can result in patients with addiction having no available funds to pay for long-term addiction care, even when they accept the need for it. The NBPP 2023 Rule proposes to refine the EHB nondiscrimination policy and provide a clear regulatory framework to evaluate plan benefit design and implementation based upon clinical guidelines and evidence. **Ensuring that nondiscriminatory benefit design is clinically based and incorporates evidence-based guidelines from reputable sources, such as health professional associations, into coverage and programmatic decisions is the right approach and consistent with ASAM policy.**[10] **ASAM supports this proposal as it should help ensure consistent application of EHB nondiscrimination policy and better safeguard individuals with addiction who depend on nondiscrimination protections.**

Standardized Plan Options (§ 156.201)

ASAM supports the NBPP 2023 Rule requirement that issuers offer at least one standardized plan at every product network type, metal level, and in every service area where the issuer also offers non-standardized plans. Plan standardization will enable individuals with addiction and their families to more easily compare plans by standardizing cost-sharing requirements, thereby allowing individuals with addiction to focus on other factors that are more crucial to their health. In addition, standardization should improve affordability by ensuring that more individuals with addiction have access to at least one plan that exempts certain important services from deductibles. **ASAM also supports requiring standardized plans to use fixed copays instead of coinsurance, which can disproportionately burden individuals with addiction and other chronic illnesses.** Further, by improving affordability to basic services, the proposal should also help address health disparities. The effectiveness of standardization in improving access and affordability is evident by the experience of states that have already adopted standardization in their state-run exchanges. ASAM applauds the federal government for now extending such a

policy to federally-facilitated exchanges and state-based exchanges that use the federal platform.

Network Adequacy (§ 156.230)

The ACA directs HHS to establish certification criteria for qualified health plans (QHPs), including criteria that require QHPs to ensure a sufficient choice of providers and provide information to current and prospective enrollees on the availability of in-network and out-of-network providers. **ASAM applauds the NBPP 2023 Rule's revisiting of network adequacy regulations to add new provisions aimed at ensuring that QHP enrollees have meaningful access to EHBs.**

First, **ASAM specifically supports the proposal to evaluate networks of QHPs and potential QHPs in the federally-facilitated exchanges prior to their certification, and post-certification review of compliance with appointment wait time standards in response to random sampling or complaints.** ASAM simultaneously urges close scrutiny of both the standards and review process before allowing states that perform plan management functions to perform their own reviews of network adequacy to ensure that both are indeed at least as stringent as federal standards and that networks are reviewed before QHPs are certified.

Second, **ASAM strongly supports the proposal to codify individual provider specialty and facility types that will be subject to time and distance standards.** Including such information in the regulation is an important step toward ensuring that QHP enrollees have meaningful access to EHBs. Specifically, ASAM applauds HHS' efforts to ensure the QHP enrollees have access to a variety of behavioral health facilities at the residential and inpatient levels of care. To that end, **ASAM supports the proposal to broaden the "inpatient psychiatry facility" category to "inpatient or residential behavioral health facility services."**

Third, **while ASAM appreciates that the newly proposed individual provider specialty list for time and distance standards covers additional provider specialty types, including "Outpatient Clinical Behavioral Heath," ASAM strongly recommends that this category be split into two groups - one for "Outpatient Clinical Mental Health" providers and another for "Outpatient Clinical Substance Use Disorder" providers.** Unfortunately, many behavioral health providers do not offer both mental health and substance use disorder services. **Furthermore, ASAM strongly urges the addition of a separate, individual provider specialty type specific to "Addiction Specialist Physicians."** Such a category should include physicians from multiple different primary specialties who obtain medical subspecialty certifications demonstrating and defining expertise in addiction treatment, as follows:

1. Subspecialty board certification in addiction medicine by the American Board of Preventive Medicine (ABPM);
2. Subspecialty board certification in addiction psychiatry by the American Board of Psychiatry and Neurology (ABPN);
3. Subspecialty board certification in addiction medicine by the American Osteopathic Association (AOA); or
4. Certification by the American Board of Addiction Medicine.

As you are aware, addiction treatment in the United States is often delivered to patients using multidisciplinary care models (MCMs) of healthcare professionals who work together to address patients' biopsychosocial needs. Examples of these models include specialized addiction treatment programs, the Patient Centered Medical Home (PCMH), the "hub-and-spoke" model, the nurse care management model, and the Collaborative Care Model (CoCM), which exist on a spectrum of integration with general medical treatment. Over time, MCMs have evolved to rely on addiction specialist physicians who can lead MCMs in addiction prevention and treatment due to their unique clinical knowledge and related skills. Adding such a provider category for time and distance is necessary to meet the health care needs of QHP enrollees with SUD. In short, putting all behavioral health providers into one category and not creating a separate, individual provider specialty category for addiction specialist physicians could cover up shortages of critical substance use disorder service providers and much-needed addiction expertise. Thus, the proposal needs further refinement, as detailed herein.

Fourth, **ASAM applauds the proposal to measure appointment wait times and greatly appreciates that HHS has identified a short list of critical service categories, including "Behavioral Health Services," to which appointment wait times should apply**.

Fifth, **ASAM supports the proposal that, with respect to plans that use tiered networks, in order to count toward the issuer's satisfaction of the network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation.** In addition, **ASAM urges HHS to provide clarity about QHP obligations to their enrollees when they are unable to meet time and distance standards or appointment wait time standards.** We know that even the most robust networks will sometimes not be unable to provide evidence-based addiction treatment services and may experience times when those providers are temporarily unavailable. As a result, ASAM urges HHS to make it clear in these situations that QHPs must hold their enrollees financially harmless for seeking care from out-of-network or higher tier addiction care providers.

Finally, **ASAM supports the proposal to require all issuers seeking certification of plans to be offered as QHPs through federally-facilitated exchanges to submit information about whether network providers offer telehealth services.** Gathering this information will help inform future rulemaking about the role of telehealth addiction treatment providers in comprising a network sufficient to deliver covered addiction treatment services to enrollees. More information is sorely needed in this regard, and ASAM supports the proposal to collect this information.

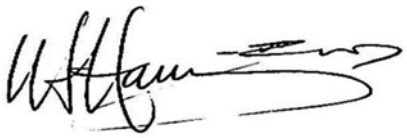
Essential Community Providers (§ 156.235)

Essential community providers (ECPs) include providers that serve predominantly individuals with low-incomes and individuals who are medically underserved. QHP issuers must include a sufficient number and geographic distribution of ECPs in their networks, where available. **The NBPP 2023 Rule proposes to raise the ECP participation standard to 35% and provide that issuers could comply with the requirement to offer contracts to at least one ECP in the category of 'other ECP providers" by offering a contract to a "Substance Use Disorder Treatment Center."** The NBPP 2023 Rule also proposes that, with respect to plans that use tiered networks,

in order to count toward the issuer's satisfaction of the ECP standards, **ECPs must be contracted within the network tier that results in the lowest cost-sharing obligation. ASAM supports these proposals and further urges HHS to require QHPs to meet this standard for each category of ECP, rather than for all ECPs take as a whole, to better ensure that QHP enrollees have adequate access to all of the important types of ECPs, including substance use disorder treatment centers**.

Thank you for your efforts and for consideration of ASAM's recommendations herein. ASAM stands ready to support your work to expand affordable access to evidence-based addiction treatment services and help alleviate some of the persistent health inequities experienced by patients with addiction. Please reach out to Kelly Corredor, ASAM's Chief Advocacy Officer, at kcorredor@asam.org with any questions.

Sincerely,



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