longer hospital stays[3], and higher risk of death than similar patients covered by health insurance.[4] Cardiovascular disease is also costly and burdensome to patients, their families and communities, and our system of care.

We have long advocated for all Americans to have access to affordable, quality health insurance coverage and care, with a focus on the prevention and elimination of disparities based on race, gender, and geography.[5] Throughout implementation of the Affordable Care Act (ACA), we remained focused on access to affordable and adequate health insurance coverage. Since then, the association has worked to ensure that

to eliminate a panoply of standards that have served to protect patients and consumers , including those related to benefit structure, cost protections, and oversight. In this letter, we focus our comments on the issues that we believe are particularly concerning for those who have, or are at risk of, cardiovascular disease and

bring down the cost of

(FPL) do not report incomes greater than 100 percent FPL in order to gain eligibility for premium assistance.

While the stated purpose of this proposal is to ensure program integrity, the realized effect would likely be to hurt people whose incomes vacillate above and below the poverty level based on inconsistent employment and/or income.

It is also unclear what, if any, pathway CMS would

Their ability to access care through SEPs helps stabilize the marketplace by ensuring people maintain coverage that is appropriate for their needs. Therefore, we are concerned about

Qualified Health Plan (QHP) Minimum Certification Standards

AHA agrees with CMS that states should play a role in the structure and management of their Exchanges. However, we believe that transferring oversight of QHP standards and certification to the states is only appropriate when states have the expertise and capacity to ensure that minimum federal network adequacy standards are met. As CMS in fact acknowledges, some states may not have the authority or means to conduct network adequacy reviews.
responsibility for this crucial consumer standard.

AHA is also concerned about keeping the Essential Community Provider (ECP) participation level at 20 percent, and we

We agree that HSA-eligible HDHPs, particularly those with expanded pre-deductible coverage, can offer value to certain individuals when paired with an HSA. However, exchange these individuals tend to be healthier and wealthier and rely in part on third-party (*i.e.,* employer) contributions to fund their HSAs. Such individuals are atypical in the exchanges and though HSAs are appealing for their lower monthly premiums, limited pre-deductible coverage may pose substantial risk to those with significant medical need.[24,25] In addition, many enrollees in HSA-eligible plans do not necessarily have an HSA or sufficient funds to adequately have

shortened open enrollment period among others, continues to erode consumers ability to understand their coverage options, gain coverage, and improve their health. We are also concerned that CMS has only provided a 30-day comment period