



December 21, 2015

Honorable Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9937-P

Dear Mr. Slavitt:

The American College of Physicians (ACP) very much appreciates this opportunity to comment on the Proposed Rule: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017. The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 143,000 internal medicine physicians (internists), related subspecialists and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We respectfully submit the following comments:

155.500: General functions of an Exchange

155.200(f) outlines requirements for State Exchanges on the Federal platform. We agree that plans offered through such exchanges should be required to abide by Federally-facilitated Marketplace (FFM) standards related to data submission, network adequacy, and essential community providers, among others. This will help to ensure consistency and eliminate confusion among marketplace shoppers while permitting states to establish more robust requirements.

155.210: Navigator program standards

ACP does not offer policy recommendations on Navigators, certified application assisters, or other assistance entities; however, we believe it is important that consumers and the newly insured understand basic health insurance concepts. Trained Navigators may be well positioned to provide post-enrollment assistance to educate consumers about health insurance concepts, in addition to providing information on exemptions from the law's responsibility provisions, tax provisions, and other consumer assistance functions.

It is important that consumers have sufficient health and health insurance literacy to make informed decisions. The literature shows that even when preventive services are exempt from cost-sharing,

patients may forgo such services because they are unaware that such services are free.ⁱ A surveyⁱⁱ of the uninsured and public or private insurance enrollees found that while most could identify terms like “premiums” and “appeal,” only 37% of respondents identified “step therapy” and 60% identified “medically necessary.” Twenty-three percent could identify characteristics of a preferred provider organization. Only 20% could accurately calculate out-of-pocket costs involving deductible, a co-payment, and co-insurance.

As health insurance becomes more complex, trained Navigators may be able to play a role in improving health care literacy by educating consumers on health insurance concepts, including cost sharing responsibilities and the cost and differences in care provided by primary care physicians and other health care professionals and settings. Given the rise of narrow network and tiered health insurance plans it has become more important for consumers to understand how their insurance works.

155.355: Annual eligibility redetermination

The proposed re-enrollment hierarchy seeks to emphasize cost over other factors in the plan selection process. ACP appreciates the proposed rule’s attempt to minimize disruption and ensure continuity during re-enrollment and plan transition periods. While premiums and cost sharing are the top factors considered for Qualified Health Plans (QHP) shoppers, other characteristics like availability of physicians and range of benefits are also important.ⁱⁱⁱ Further, it is apparent that many consumers tend to focus on premium cost, rather than total out of pocket cost, a serious concern given the proliferation of high-deductible health plans, coinsurance and other insurance models that shift a substantial out-of-pocket burden to the enrollee. The proposed re-enrollment strategy for transitioning silver-level QHP enrollees to similar active silver-level products offered by the same issuer appears sensible and it may help to preserve access to cost-sharing assistance if applicable. We urge that provider networks and other important factors be considered when determining if another silver-level product is “similar” to the consumers’ current product. Re-enrollment policies should make every effort to ensure continuity and preserve the patient-physician relationship.

156.122: Prescription Drug Exception Process

ACP remains strongly supportive of the requirement that QHPs provide a prescription drug formulary exception process that provides a pathway to access clinically appropriate drugs not covered by the health plan. We recognize that States may have existing appeals process rules in place but urge the final rule to clarify that the process described in 156.122(c) be considered a floor and would allow States to require a more stringent exception process if necessary.

156.230: Network Adequacy Standards

In its 2014 comment letter on the Notice of Benefit and Payment Parameters for 2016, the College expressed its support for more stringent quantitative network adequacy criteria; ongoing monitoring and oversight of provider networks; transparent provider network development criteria; accurate, easily accessible and up-to-date provider directories; and requirements that QHPs should be prohibited from excluding health care clinicians whose practices contain substantial numbers of patients with expensive medical conditions.^{iv}

Evidence shows that networks are narrowing, potentially restricting patients from accessing their preferred provider:

- A report by the Robert Wood Johnson Foundation found that 41% of 2014 silver QHP networks were small (they include 10-25% of office-based participating providers in the area) or extra small (less than 10% included in network).^v
- By specialty, 36% of primary care networks and 23% of internal medicine specialty networks were small or extra small.
- McKinsey & Co. found that in plan year 2015, narrow or tiered hospital network plans and tiered plans comprised 45 percent of all exchange plan networks in the United States.^{vi} The report also notes that “In our consumer survey, 44% of those who bought an ACA plan for the first time this year reported that they did not know the network configuration associated with their plan.

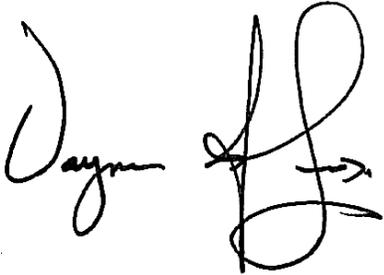
We applaud the agency’s proposal to determine that a State’s network adequacy assessment methodology is acceptable if it includes quantitative measures. We believe that states should be required to adopt quantitative criteria to more accurately discern whether a health plan’s provider network is adequate. While the College cannot offer specific recommendations regarding which quantitative metrics should be required, it is worth noting that the network adequacy measures for Medicare Advantage plans are minimum number of providers/facility, maximum travel time, and maximum travel distance.^{vii} According to a May 2015 Commonwealth Fund report, 23 states use time and distance standards to determine marketplace plan network sufficiency.^{viii} Additionally, 11 states currently consider maximum wait times to evaluate marketplace plan network adequacy. Wait times have proven to be a problem in other health insurance programs: a report by the HHS Office of the Inspector General found that over a quarter of Medicaid managed care beneficiaries had appointment wait times of over one month. By using maximum appointment wait time measures, CMS and States can assure that provider networks are sufficiently broad so that patients have timely access to primary care and specialist physicians.

Regarding the provider transitions proposal at 156.230(e), ACP has previously joined other medical organizations in calling for policies that ensure a smooth transition and continuity of care when a physician’s contract with a Medicare Advantage organization is terminated without cause.^{ix} ACP remains very concerned that physicians are being unjustly terminated from contracts as such actions can interrupt care and undermine the patient-physician relationship. We agree that QHPs should be required to provide written notice of a discontinued provider at least 30 days prior to the effective date of the change although patients should be notified as far in advance as possible to ensure new care arrangements can be made. The notice should be provided to all enrollees who are patients seen by the physician in the past one year or in the time the patient has been with the insurer. Further, following such network changes efforts should be made to ensure that the network continues to meet sufficiency requirements and provider directories must be updated in a timely manner to mitigate confusion. We also support the continuity of care provision for cases where a provider is terminated without cause. This would allow an enrollee to continue active treatment until completion or 90 days, whichever is shorter, at in-network cost-sharing rates.

Finally, we strongly reiterate our support for requiring health issuers to make available their selection and tiering criteria for review and approval by HHS and individual states. Such a proposal would reflect the new NAIC Network Adequacy Model Act access plan language and ensure that networks are being developed to emphasize high quality care and not just cost containment.

Thank you for the opportunity to provide comments on this important proposed rule.

Sincerely,

A handwritten signature in black ink, appearing to read "Wayne J. Riley". The signature is fluid and cursive, with the first name "Wayne" written in a larger, more prominent script than the last name "Riley".

Wayne J. Riley, M.D., MPH, MBA, MACP
President
American College of Physicians

References

- i Reed ME, Graetz I, Fung V, Newhouse JP, Hsu J. In Consumer-Directed Health Plans, A Majority of Patients Were Unaware of Free or Low-Cost Preventive Care. *Health Aff.* 2012;31(12):2641-2648. Accessed at <http://content.healthaffairs.org/content/31/12/2641.long> on October 8, 2015.
- ii Paez KA, Mallery CJ. A Little Knowledge is a Risky Thing: Wide Gap in What People Think They Know about Health Insurance and What They Actually Know. American Institutes for Research Issue Brief. October 2014. Accessed at http://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amendd.pdf on October 9, 2015.
- iii Hamel L, Norton M, Levitt L, Claxton G, Cox C, Pollitz K, Brodie M. Survey of Non-Group Health Insurance Enrollees. Kaiser Family Foundation. June 19, 2014. Accessed at <http://kff.org/report-section/survey-of-non-grouphealth-insurance-enrollees-section-4/>
- iv American College of Physicians. Letter to Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services Regarding the Proposed Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P). Accessed at https://www.acponline.org/acp_policy/letters/letter_cms_proposed_rule_benefit_payment_parameters_2016_2014.pdf
- v Polsky D and Weiner J. The Skinny on Narrow Networks in Health Insurance Marketplace Plans. The Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation. June 2015. Accessed at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027 on December 21, 2015.
- vi Bauman N, Bello J, Coe E, Lamb J. Hospital networks: Evolution of the configurations on the 2015 exchanges. McKinsey Center for U.S. Health Reform. April 2015. Accessed at <http://healthcare.mckinsey.com/sites/default/files/2015HospitalNetworks.pdf> on December 21, 2015
- vii Centers for Medicare and Medicaid Services. CY2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance. Accessed at https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2016_MA_HSD_Network_Criteria_Guidance.pdf on December 21, 2015
- viii Giovannelli J, Lucia K, Corlette S. Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks. The Commonwealth Fund. May 5, 2015. Accessed at <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/state-regulation-of-marketplace-plan-provider-networks> on December 21, 2015
- ix Letter to Marilyn Tavenner, Administrator, Centers for Medicare and Medicaid Services, Regarding Medicare Advantage. February 12, 2015. Accessed at https://www.acponline.org/acp_policy/letters/ma_draft_2016_call_letter_2015.pdf on December 21, 2015