



February 11, 2014

Kathleen Sebelius  
Secretary  
United States Department of Health and Human Services  
200 Independence Ave. SW  
Washington, D.C. 20201

Dear Secretary Sebelius,

The American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine specialists (internists), related subspecialists, and medical students, writes to offer appreciation for your work to implement the Affordable Care Act. ACP is pleased that the Administration has mobilized the necessary personnel and resources to facilitate health insurance marketplace functionality and enrollment. With millions of Americans now enrolled or preparing to enroll in marketplace-based qualified health plans and Medicaid, it is apparent that the Affordable Care Act is approaching its goal to reduce the number of uninsured, improve the quality of the health care delivery system, and drive down costs.

ACP remains committed to supporting the Affordable Care Act and enabling the nation's internists to provide their patients with the tools to enroll in affordable health insurance and steer the nation's health care system to deliver high-quality, high-value care. In 2013, ACP launched an ACA Enrollment education [campaign](#), providing members with state-specific reports outlining ACA coverage provisions and resources to help our members assist their patients in finding the health insurance that best meets their needs. The College also developed a Medicaid expansion advocacy campaign, assisting our chapters push for expansion of the Medicaid program in their state.

While the College reaffirms its support for the ACA, we also call for improvements to help ensure patients can:

- Access the physicians and hospitals of their choice without unreasonable restrictions
- Receive medically-necessary medications and services
- Obtain swift decisions when appealing insurance plan decisions; and
- Have accurate, up-to-date information about the benefits covered by and the clinicians and hospitals contracted with qualified health plans (QHPs).

**The College is pleased that on February 4, the Centers for Medicare and Medicaid Services released a letter to insurers in the federally-facilitated marketplace that would strengthen network adequacy requirements, increase the supply of essential community providers, and provide greater transparency and scrutiny of prescription drug formularies.<sup>1</sup> We look forward to working with you to improve upon the new requirements, as discussed below.**

### Networks: Robust Standards and Transparency

Having an insurance card is essential to getting health care, but equally important is ready access to physicians of the patient's choice. Health plan networks that force patients to sever their relationship with their longtime physician, or travel great distances to their preferred hospital or cancer-care center, subvert the intent of the Affordable Care Act's effort to expand access to quality health care. Transparency in the network development process is imperative. The recent situation with UnitedHealthcare's Medicare Advantage plans<sup>2</sup> — where abrupt changes in the plan's network resulted in confusion for patients and physicians — highlights the need to require QHPs and Medicare Advantage plans to disclose network development criteria and to regularly scrutinize networks for adequacy and stability.

To avoid the public backlash that characterized the managed-care boom of the 1990s, patients must feel secure that health plans will not place unreasonable restrictions on their ability to see a clinician of their choice without unreasonable delay, inconvenience or out-of-pocket cost, whether they reside in a large city, suburban or rural area. As patients enroll in new and different QHPs, facilitating continuity of care should be an explicit goal, especially for patients with multiple chronic conditions who rely on a variety of physicians to serve their medical needs.

**To help achieve these goals, ACP proposes improvements to the existing standards and rules governing QHPs to:**

- **Provide patients with ready access to up-to-date network directories at the time of plan selection;**
- **Ensure a transparent and cooperative process for developing networks of participating physicians and hospitals; and**
- **Maintain ongoing oversight and monitoring of health-insurance marketplace plans to identify and rectify potential network access problems.**

*Network Adequacy Standards:* A number of reports indicate that many QHPs are offering narrow networks, sharply restricting the number of physicians and hospitals from which patients can receive care. If organized correctly, health plan networks can be used to better coordinate care and encourage use of high-quality physicians. However, over-strict networks endanger continuity of care and fracture the physicians-patient bond. The ACA establishes a federal standard for network adequacy and states

may establish stricter standards. While these safeguards are important, we are already seeing that narrow networks are posing problems for those seeking marketplace-based insurance:

- Regulators in Maine, Wisconsin, and other states have intervened to stop insurers from selling narrow network plans. In Washington State, one rejected insurance carrier's network would have forced enrollees to travel over 120 miles to see a gastroenterologist.<sup>3</sup>
- A California insurer permits access to only 204 primary care physicians in its San Diego area QHP, one-third the size of its employer-based plan's provider network.<sup>4</sup>
- A New Hampshire hospital was excluded from exchange contract negotiations, despite having "lower hospital charges than its closest competitors, as well as consistently high marks for quality care," arguing that the network selection process was not transparent.<sup>5</sup>
- A recent study by McKinsey and Co. found that about two-thirds of marketplace-based plan hospital networks are "narrow or ultra-narrow."<sup>6</sup>

ACP supports the minimum network adequacy standards established in federal regulations<sup>7</sup> requiring QHPs to ensure access to essential community providers, and a network sufficient in number and types of clinicians including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. We are encouraged that **CMS states in the February 4 letter that it intends in 2015 to review plan lists of participating physicians and hospitals to determine whether the networks provide sufficient access without unreasonable delay, focusing on access to hospital systems, mental health, oncology, and primary care clinicians. CMS states that it intends to use its review to develop time and distance and other standards for future network review.**

We recommend that CMS and state regulators strengthen existing requirements in the following ways:

- **Improve current network adequacy standards by taking into account additional criteria—including patient-to-physician ratios, use of out-of-network clinicians and hospitals, and urban, suburban, and rural area-relevant standards—as indicators of access.** These would be in addition to developing time, distance and other standards for QHP networks beginning in 2015, as proposed in CMS's February 4 letter to insurers.
- **Develop network adequacy standards for PPOs, including factors such as whether a hospital contracts with an in-network physician.**<sup>8</sup>
- **Continuously monitor network adequacy.** We are encouraged that in an April 2013 letter to insurers, CMS stated that it will be monitoring network adequacy via complaint tracking and random spot checks of QHP network data.<sup>9</sup> We recommend that such compliance and complaint information be made available to the public.
- **CMS must work closely with state regulators to address network adequacy concerns that are most relevant to each state (and the individual health plan service areas within each state).** We are encouraged that the February 4 letter extends existing federally-facilitated marketplace network adequacy standards through increased monitoring of the access provided to primary care physicians, hospital systems, mental health clinicians and facilities, and oncology care.

- **The College also supports the enhanced requirements for the inclusion of essential community providers (ECP) such as federally qualified health centers, Ryan White HIV/AIDS providers and safety net hospitals; however, the 30% ECP threshold should be a minimum, and QHPs should be encouraged to incorporate additional ECPs to meet the needs of patients in the service area. CMS should closely scrutinize QHP requests for exceptions to this rule and closely monitor plans that are granted exceptions, requiring changes as needed. Contingency plans must prioritize continuity of care with the patient's preferred health care clinician.**

*Network Development and Transparency:* ACP supports efforts to consider value in the development of health plan networks, as long as the process is balanced, transparent, fair, and provides real choice. The process through which networks are developed and the factors considered by insurers should be made public; CMS and state regulators should require further safeguards to ensure access and continuity of care:

- **Mandate that QHPs provide physicians and their patients advance notice of network changes and the opportunity to appeal.**
  - **Physicians should be provided with detailed reasons as to why their contract was terminated.**
  - **They should be able to comment on and challenge alterations as necessary.**
  - **All network selection and deselection decisions should be on record**
  - **Health plans or networks should provide public notice within their geographic service areas when physician applications for participation are being accepted**
- **Ensure that physicians have the option of applying to any health care plan or network in which they desire to participate and to have their application judged based on objective criteria that are available to both applicants and enrollees**
- **Require transparency in the criteria used by QHPs to determine who will be allowed into networks. Performance measures and methodologies used for network selection and tiering should conform to the following standards:**
  - **Measures should be meaningful to consumers and reflect the importance of patient-centered care.**
  - **Physicians and physician organizations should have input to these programs and the methods used to stratify performance. They should also have access to the information collected and should be given notice before individual information is released.**
  - **Measures and methodology should be transparent, valid, accessible, and understandable by consumers, physicians, and other clinicians.**
  - **Measures should be based on national standards, primarily standards endorsed by the National Quality Forum (NQF). Standards from other groups and organizations may be used, but they should be replaced by NQF standards once available.**
- **QHPs should consider multiple criteria related to professional competency, quality of care, and the appropriate utilization of resources. In general, no single criterion – including cost - should provide the sole basis for selecting or excluding a physician from a plan's network.**

- In keeping with nondiscrimination guidelines, QHPs should be prohibited from excluding health care clinicians because their practices contain substantial numbers of patients with expensive medical conditions.

ACP reiterates its support for the recommendations listed in the November 6, 2013 [letter](#) from the College and other physician membership organizations to CMS Commissioner Marilyn Tavenner, including calling for Medicare Advantage (MA) plan sponsors to document that patients received accurate network information, informing patients of their rights to retain their physician, and providing physicians with information on how to challenge and appeal network changes.

*The Consumer Shopping Experience and Network Directories:* To support informed choice, consumers should have access to accurate and up-to-date information about which physicians, hospitals, specialized treatment centers, and other sources of care are participating in the QHPs offered through the exchanges. Regular provider directory updates, such as those mandated by state network adequacy laws in Texas and California must be required of all QHPs so that patients can be assured that their preferred clinician is in their plan's network. The College recommends the following:

- **Require QHPs to provide up-to-date network directories in real-time when a potential enrollee is choosing a plan, including making prompt updates upon receipt of new information relating to network participation.**
  - **Create an online search tool to allow users to search by clinician and hospital name and filter out health plans that do not include the consumer's chosen clinician or hospital in network. ACP is very pleased that the February 4 letter indicates that the agency is considering collecting the necessary data to create such a search tool. Marketplace websites should also make available a formulary search tool, enabling consumers to search for plans based on whether their medications are covered in the plan's formulary.**
- **Create a special enrollment period to allow patients to choose another QHP if an outdated network directory has incorrectly listed an enrollee's preferred physician as being part of the network.** ACP appreciates the December 17, 2013 interim final rule *urging* (but not requiring) QHPs to provide the most current online directory to marketplace plan shoppers and treat out-of-network physicians as in-network if they were listed in the QHP's in-network provider directory at the time of the patient's enrollment. **If this cannot be accomplished, CMS should require a special enrollment period allowing patients to choose another health plan.** This may be permitted in 45 CFR 155.420(d)(5), which states that a special enrollment period may be triggered if "(a)n enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee."
- **Require QHPs to establish "health care provider hotlines" to connect physicians, hospitals and other providers to QHP representatives to answer questions, verify patient enrollment, and obtain other information.** Better access to information is crucial, especially as patients transfer between plans and/or health insurance programs and experience changes in advance premium

tax credit and cost-sharing assistance eligibility. QHPs should facilitate physicians' verification of enrollment and health plan information through an online portal and must inform physicians that they are included in-network. This will ensure that clinicians can maintain a patient panel that will guarantee access for existing patients and help clinicians accurately determine whether they can absorb additional patients covered by marketplace-based plans.

90-day grace period prior to termination of coverage for non-payment of premiums. The October 3, 2013 Federally-Facilitated Marketplace Enrollment Operational Policy & Guidance Manual states that QHPs must notify providers of the possibility of denied claims for services incurred during months two and three of the grace period for enrollees receiving advance premium tax credits and that CMS expects issues would provide such notice within the first month of the grace period and throughout months two and three. This should be improved.

- **ACP recommends that QHPs be required to adopt standards enabling physicians to access real-time patient enrollment verification, patient cost-sharing responsibility, and claims processing information. QHPs should be required to provide real-time notification when a patient enters the 90-day grace period. Notification should provide information on which month of the grace period the enrollee is in. Failure to notify a physician of grace period entry should initiate a binding eligibility determination upon the insurer, requiring the QHP to pay claims during the grace period.**
- **CMS should track QHP adherence to grace period notification standards and consider such criteria during the initial certification and recertification process.**

Require QHPs to establish a stronger in-network exception process: The ACA's internal and external appeals process is a major step forward to ensure patients can obtain fair, objective determinations regarding disputed claims. However, the process can be improved by expediting decisions, expanding the scope of the decisions that can be appealed, and simplifying the information submission process:

- **Create an appeals process to authorize in-network cost-sharing if a medically necessary service is not available within the network but is available from an out-of-network physician willing to accept terms of the service. Additional costs related to the service should be absorbed by the QHP. This exception is permitted for preventive services<sup>10</sup>, but it should be expanded to include other essential health benefits.**
- **To help expedite the appeals process and reduce any potential administrative burden on physicians, efforts should be made to ensure that physicians have easy access to necessary appeals documentation and are able to submit them through a variety of means, including an online portal. QHPs should be required to have 24-hour telephone access for physician-to-physician dialogue with the ability to resolve any clinical or medical necessity issues.**

Improve the prescription drug formulary exception process: ACP appreciates that the February 4 letter strongly recommends that QHPs facilitate continuity of care by providing off-formulary drugs to enrollees during the first months of enrollment without going through the exceptions process. This

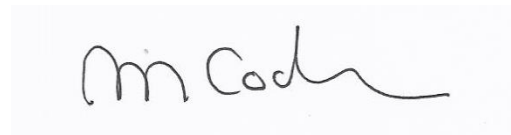
temporary transitional policy may help for certain acute care episodes, but additional safeguards should be established:

- **QHPs with restrictive formularies should allow patients to continue to receive disputed medication during an entire exception review process, and if an exception is granted, continue to provide coverage for the exception drug during subsequent plan years. There must be a mechanism for expedited internal and external review and appeals in urgent health situations. Federal and state regulators should mandate that insurers and independent review entities provide a decision to the patient and provider/prescriber within 24 hours for urgent health situations or 72 hours for non-urgent situations.** CMS should evaluate the prescription drug exception and the claims denial appeals processes as well as appeal approval/denial rates as QHP certification and recertification criteria.
- **Federal and state regulators and other stakeholders must closely monitor formularies and other benefit design features to ensure that coverage does not exclude patients with complex chronic conditions, including patients with cancer, transplants, mental health treatment, HIV/AIDS, and hepatitis C. Such limited formularies and plan restrictions would violate the spirit of the ACA's nondiscrimination provisions which prohibit discrimination based on factors including health status, disability, age, race, gender, and sexual orientation.** A July 2013 report issued by the Georgetown University Health Policy Institute identified troubling concerns from stakeholders – including state regulators and consumer advocacy groups – about discriminatory benefit designs and highlighting the potential for discrimination in the design of limited networks and drug formularies. Among the recommendations, stakeholders stressed the need for robust, continuous monitoring of potentially discriminatory benefit designs.<sup>11</sup>
  - The College is encouraged that the February 4 letter notes that CMS will provide increased scrutiny of essential health benefit packages to prevent plans from discriminating against vulnerable, complex-needs patients.
  - The College supports requiring QHPs to attest that benefit packages are not discriminatory.
  - We support CMS's intent to monitor complaints and analyze appeals. The College especially welcomes enhanced oversight of plans that require prior authorizations and/or step therapy requirements in a particular drug category or class.
  - We also request that CMS consider offering alternatives to arbitrary prior authorization requirements such as creating incentives for the application of appropriate use criteria, and excusing medical practices that are participating in value-based payment programs from prior authorization requirements.
  - QHPs that violate anti-discriminatory benefit design rules should be stripped of certification.

The American College of Physicians appreciates your consideration of these recommendations. The College believes that the Affordable Care Act represents an historic step forward to providing all Americans with access to affordable coverage without regard to their health status, their gender, where they work or live, or how much they earn. We offer the recommendations in this letter in the spirit of

working collaboratively with the administration, health insurers, state regulators, and other stakeholders to identify and act to reduce barriers to continuity of care and help ensure that patients get the care they need, from a physician they trust, and by doing so, help the Affordable Care Act further achieve its goal of creating a more fair, accessible, efficient and effective health care system for all.

Sincerely,

A handwritten signature in black ink that reads "Molly Cooke". The signature is written in a cursive, flowing style.

Molly Cooke, MD FACP  
President  
American College of Physicians

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<sup>1</sup> Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. Draft 2015 Letter to Issuers in Federally-facilitated Marketplaces. February 4, 2014. Accessed at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf>

<sup>2</sup> Cha AE. Doctors cut from Medicare Advantage networks struggle with what to tell patients. *Washington Post*. January 25, 2014. Accessed at [http://www.washingtonpost.com/national/health-science/doctors-cut-from-medicare-advantage-networks-struggle-with-what-to-tell-patients/2014/01/25/541bfbd8-77b4-11e3-af7f-13bf0e9965f6\\_story.html](http://www.washingtonpost.com/national/health-science/doctors-cut-from-medicare-advantage-networks-struggle-with-what-to-tell-patients/2014/01/25/541bfbd8-77b4-11e3-af7f-13bf0e9965f6_story.html)

<sup>3</sup> Washington State Office of the Insurance Commissioner. An open letter from Mike Kreidler about insurance plans filed for Washington's exchange. August 22, 2013. Accessed at <http://wainsurance.blogspot.com/2013/08/an-open-letter-from-mike-kreidler-about.html>

<sup>4</sup> Zamosky L. Narrow Networks in covered California Plans Causing confusion in San Diego. *California HealthLine*. December 12, 2013. <http://www.californiahealthline.org/insight/2013/narrow-networks-in-covered-california-plans-causing-confusion-in-san-diego>

<sup>5</sup> Felgar A. Transparency would improve health exchange: Competition will only resolve some of the flaws of the new system. *New Hampshire Business Review*. January 10, 2014. Accessed at <http://www.nhbr.com/January-10-2014/Transparency-would-improve-health-exchange/>

<sup>6</sup> Appleby J. Marketplace Plans' Networks Are Very Small, Study Finds. *Kaiser Health News*. December 12, 2013. Accessed at <http://capsules.kaiserhealthnews.org/index.php/2013/12/marketplace-plans-networks-are-very-small-study-finds/?referrer=search>

<sup>7</sup> 45 CFR 156.230

<sup>8</sup> McCarty S and Farris M. ACA Implications for State Network Adequacy Standards. Robert Wood Johnson Foundation. August 2013. Accessed at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/08/aca-implications-for-state-network-adequacy-standards.html>

<sup>9</sup> Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services. Affordable Exchanges Guidance: Letter Issuers on Federally-facilitated and State Partnership Exchanges.



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<sup>10</sup> U.S. Department of Labor. FAQs about Affordable Care Act Implementation Part XII. February 20, 2013. Accessed at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>

<sup>11</sup> Keith K, Lucia K, Monahan C. Nondiscrimination Under the Affordable Care Act. Georgetown University Health Policy Institute Center on Health Insurance Reforms. July 2013. Accessed at [http://chir.georgetown.edu/pdfs/NondiscriminationUndertheACA\\_GeorgetownCHIR.pdf](http://chir.georgetown.edu/pdfs/NondiscriminationUndertheACA_GeorgetownCHIR.pdf) on January 28, 2014.