

December 22, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule

Dear Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule regarding Notice of Benefit and Payment Parameters for 2016. As millions of Americans enroll in marketplace qualified health plan (QHP) coverage during the second open enrollment period, the AMA is pleased that in the proposed rule, CMS has acknowledged many of the concerns that the AMA and other physician and patient advocacy groups have raised about barriers to access experienced by enrollees in QHP coverage during the first year of expanded access to insurance coverage under the Affordable Care Act (ACA). These concerns have focused on network adequacy, provider directory access and accuracy, restrictive formularies, continuity of care, exceptions and appeals procedures, and lack of transparency. The proposed rule makes an effort to address many of these issues, and we urge you to ensure that the final rule adopts the improvements to access outlined in the proposed rule, and addresses additional areas, as discussed in more detail below.

Prescription Drug Benefits (§ 156.122)

Alternative Approaches to Drug Formulary Development

We agree with CMS that the current system for assessing compliance with the Essential Health Benefits (EHB) requirement to cover prescription drugs has been inadequate and needs improvement. The current process of relying on the greater of one drug per class or the number of drugs in each class in the state's benchmark based on the U.S. Pharmacopeia (USP) classification system has many shortcomings. As noted in the proposed rule's preamble, USP was designed for the Medicare Part D program, which has a different population than the qualified health plans. This has resulted in drugs not being covered that are needed by patients, including newly approved medications, and plans removing necessary drugs mid-year. Using the American Hospital Formulary System (AHFS) as a standard for classifying drugs would be preferable to the USP system since it is more detailed, widely used and accepted, and more frequently updated. The AHFS is a four-tier hierarchy that is more granular than the two-tier USP system and often

better captures the differences between medicines. If CMS adopts a count-based system using AHFS, it should take advantage of all four tiers to capture as many differences between medicines as possible.

We also support utilizing Pharmacy and Therapeutic (P&T) committees that select what medications plans cover based on treatment guidelines and expert knowledge of specific health conditions and their treatment. Requiring them to meet at least quarterly would help ensure newly approved drugs can be added to plan formularies. We believe that strong standards are needed to ensure P&T committees are independent and have strict conflict of interest standards to represent patients' best interests. In addition, physicians participating in health plan networks should oversee and participate on properly elected P&T committees that develop and maintain plan formularies, and approve such formularies. Moreover, as discussed further below in the section on exceptions processes, health plans must have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated; this process must impose minimal administrative burdens, and it must include access to a formal appeals process for physicians and their patients.

We believe making these changes will help improve the formulary development process and ensure a more robust formulary for patients. We urge CMS to move forward with requirements that combine a drug count system that, at a minimum, uses the current standard of greater than one drug or the number of drugs covered by the benchmark, while using the most recent AHFS, combined with the expert recommendations of the P&T committee. If CMS chooses to maintain the USP system, plans should be required to use the most recent version, which is currently Version 6.0, and is more reflective of today's FDA-approved medications. We also urge CMS to use the new process in 2016, rather than waiting for the 2017 plan year.

Given the widespread use of restrictive drug formularies, multiple drug tiers, and step therapy in the exchange QHPs, formulary review by CMS and state regulators must go beyond simply assessing whether a plan is covering a sufficient number of drugs in each class or category. Regulators need to examine which tiers drugs are placed on and whether prior authorization and step therapy are used appropriately. It is critical that cost not be the sole criterion for imposing utilization restrictions. If a plan's formulary is constructed in such a way as to place needed specialty medications in the highest tiers, consumers will suffer a large financial burden and may delay the purchase of needed drugs. As a result, tiered formularies can result in reduced medication adherence, worsening health outcomes, and higher costs. Therefore, formulary tiering should be closely monitored to ensure that patients have access to appropriate medicines on lower cost formulary tiers. Formularies should be reviewed to ensure that medicines are only placed on a higher cost tier when there is a therapeutically similar medicine on a lower cost tier.

Exceptions Process

We appreciate that CMS has listened to concerns raised by the AMA and other interested stakeholders over the last year regarding the need for plans to have a strong, enforceable exceptions process to enable enrollees to access medications not on a plan's formulary, and we are pleased to see further improvements to the exceptions process in the proposed rule. We support the provision in the proposed rule that continues to require that insurers provide an exceptions process permitting enrollees, their designees or physicians, to request an expedited review when necessary based on exigent circumstances, such as when an enrollee suffers from a serious health condition that might jeopardize the enrollee's life, health, or

ability to regain maximum function, or is undergoing a current course of treatment with a non-formulary drug. Under this requirement, a health plan must make a decision and notify the enrollee or physician within 24 hours. We also support the proposed rule's continuation of the requirement that a health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

The AMA also supports CMS' proposal that plans must add a "standard exceptions process," under which an enrollee or physician could request coverage of a clinically appropriate non-formulary drug in non-exigent circumstances and receive a decision within 72 hours. Coverage would continue for the duration of the prescription, including refills. We also agree with the proposal that any drug approved under an exceptions process, either the expedited or standard process, be considered as part of the EHB and that any cost-sharing for such drug counts against the maximum out-of-pocket limit. In addition, the AMA believes that any drug approved through an exceptions request should continue to be provided in subsequent years without the enrollee having to go through another exceptions process.

The AMA supports the proposal that an enrollee denied an exception could appeal to an accredited independent review organization, which would have to decide the appeal in the same timeframes permitted for the initial decision. However, we believe it is important for CMS to recognize that the exceptions process, including the independent external review, is not a substitute for a robust and non-discriminatory formulary, but is a key patient protection; we recommend that CMS add some language to this effect to the preamble of the proposed rule.

Formulary Transparency

The AMA strongly supports the proposed rule's provisions to increase formulary transparency. Under the proposal, health plans would be required to publish on their public website up-to-date, accurate, and complete lists of all covered drugs on their formulary drug list where they could be accessed without a consumer creating or accessing an account or entering a policy number. If an issuer offers more than one plan, the list would need to clearly identify which formulary goes with which plan. The information would need to include any tiering structure that the plan has adopted and any restrictions on obtaining the drug. In addition, CMS notes in the preamble that the information on formularies should be linked to the URL link for obtaining prescription drug information in the Summary of Benefits and Coverage; however, CMS does not include this expectation in the actual regulatory text and we recommend that CMS do so. We believe that all of these additions will improve the transparency of prescription drug benefits in EHB plans and help patients make the best decisions to meet their needs, and urge that they be implemented in 2016.

We also think that these provisions would be strengthened by including cost sharing information, such as the enrollee's applicable pharmacy deductible, copayment, or cost-sharing percentage, for each formulary tier. Since plans are using co-insurance more frequently, plans should provide what the actual enrollee cost sharing will be in dollar terms. We believe this information is critical to allow informed consumer decision-making about out-of-pocket expenses that may be incurred, and urge CMS to require this information in the final rule.

CMS is also considering making insurers release machine-readable information so that third parties could use it to develop search and shopping tools. There is currently no standard formulary design and some

formularies have search capabilities while others do not. We support this proposal as a way to make it easier for patient and consumer groups to analyze plan data and develop tools, such as a plan finder or benefit calculator that matches an individual's prescriptions with appropriate plans, similar to the one utilized by the Medicare Part D program.

One area that CMS does not address is restrictions on the ability of plans to change formularies during an enrollee's period of coverage. While plans should be able to make changes during the plan year to add newly approved or newly approved uses for drugs, as well as remove drugs for safety reasons, plans should not be allowed to take drugs off their formulary for non-safety reasons or move them to higher cost-sharing tiers year during an enrollee's period of coverage due to the potential for adverse and medical and financial implications to the patient.

Choice in Pharmacy Access

The AMA supports CMS' proposal to prohibit insurers from limiting access to drugs only to mail order pharmacies. While mail-order pharmacies may be more cost-effective and more convenient for enrollees, obtaining drugs via mail order may not always be viable. The same economic opportunities should be provided to brick-and-mortar pharmacies as given to mail service pharmacies, and access to network retail pharmacies should be an option provided to enrollees. This change should be implemented in 2016, rather than waiting until 2017.

Transition Coverage

CMS encourages insurers to allow new enrollees access to non-formulary drugs, or drugs that would otherwise require prior authorization or step therapy, which enrollees have been prescribed and are currently taking, for their first 30 days of coverage in a new plan, to allow sufficient time for enrollees to go through the prior authorization or drug exception processes in their new plans. While we appreciate CMS' acknowledgement of the need for insurers to accommodate new enrollees' need for transition coverage, we believe CMS should make this a requirement in the final rule and consider extending the transition fill period to 90 days. This would allow patients sufficient time to talk to their physicians and new health plan about medication options. Medicare Part D uses a 90-day transition period, and we urge CMS to require this longer transition period for QHPs. Transition fills are an important consumer protection and will help patients change plans without fear of going without their current medicines.

Discriminatory Benefit Design (§ 156.125)

In order to safeguard patients and assure a stable marketplace, the ACA includes significant non-discrimination provisions for consumers. Until now, however, CMS has not issued clear guidance on how to ensure that consumers receive the benefit of these protections with respect to essential health benefits. We are pleased to see that CMS has addressed the issue of discriminatory benefit design discussion in the preamble to the proposed rule, including a reminder that plans must not design benefits in a discriminatory manner, and has acknowledged that they have seen benefit designs that they believe would discourage enrollment by individuals based on age or on health conditions, in effect making these plan designs discriminatory. In this discussion, CMS provides examples of benefits that would be discriminatory, such as placing limits on or excluding services. Age limits, for example, would be discriminatory if applied to services that are effective for all ages; an insurer that puts most or all drugs

that treat a specific condition on the highest cost tiers would in effect be discriminating against or discouraging individuals with those chronic conditions from enrolling. This is particularly important to ensure that patients with chronic conditions, such as patients with HIV/AIDS or cancer, or those who need specialized treatment, such as for mental health or substance use disorders, are not discriminated against.

While the discussion in the preamble is helpful as a guideline to plans and the states that review plans for potential discrimination, we urge CMS to develop accompanying regulatory language. For example, CMS indicates that insurers that reduce or limit benefits targeting a particular group without justifications based on clinical guidelines and medical evidence, and reasonable medical management, may be asked by CMS or a state regulator to explain why their plan design is not discriminatory. Especially for those states which have opted against creating their own exchanges, we believe regulatory language is needed to flesh out the non-discrimination requirements. The regulatory language should prevent plans from meeting EHB requirements if, for example, they place most prescription drugs for a condition on the highest cost sharing tier or if they do not cover commonly prescribed combination and extended release products. At a minimum, it would be useful for CMS to create tools that states could use to assess formularies.

Network Adequacy, Provider Directories, and Essential Community Providers (§ 156.230, 156.235)

One of the AMA's most significant concerns about QHPs offered through the exchanges in 2014 has been the widespread use by such plans of narrow and tiered networks. We agree with CMS' statement in the preamble of the proposed rule that networks that provide sufficient access to benefits are a priority for consumers, and we would add they are equally, if not more important, for physicians, especially those who have long-standing relationships with their patients. We appreciate, and support, CMS' clarification in the preamble and the proposed rule that a provider network includes only providers that are contracted as in-network and that the general availability of out-of-network providers cannot be counted in determining network adequacy. We also support CMS' acknowledgement that new enrollees in QHPs may need a transition period of 30 days after joining a plan during which they be allowed to use their current providers if they are under an ongoing course of treatment.

We are very pleased to see that CMS has strengthened the requirements for provider network directories. Inaccurate and out-of-date directories have been one of the biggest problems and sources of frustration for both patients and physicians during the first year of QHP implementation. Provider directories should provide as much detail as possible about network providers. CMS proposes to require a QHP issuer to publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, as well as providers' location, contact information, specialty, medical group, and any institutional affiliations. This information must be easily accessible to plan enrollees, prospective enrollees, the state, the exchange, HHS, and the Office of Personnel Management. The issuer must update the directory at least monthly, and as with the proposed formulary transparency requirements, the issuer must ensure that consumers are able to view all of the current providers for a plan on the plan's public website through a clearly identifiable link without having to create or access an account or enter a policy number. CMS notes that the general public should be able to easily discern which providers participate in which plan(s) and provider network(s) if the plan uses multiple networks, and the plan(s) and network(s) associated with each provider should be clearly identified on the website. We support all of these proposed requirements, which we believe will improve transparency and enable

consumers to better understand and choose the best plans for their circumstances. In addition, we urge CMS to consider requiring issuers to include the following information in the directories:

- Website address;
- Hours of operation;
- If the network is tiered, a conspicuous disclaimer indicating which tier the provider is in, how that provider tier impacts a consumer's financial or other obligations, and any appeals or prior authorizations processes;
- Names and locations of the hospital(s) where the physician or other provider has medical staff privileges and whether those hospitals are part of the provider network;
- Indication of whether the physician may be selected as a primary care physician; and
- Generally accepted and appropriate quality measures, if used by the insurer.

CMS is also considering requiring insurers to submit provider directory information in machine-readable form or using an HHS-designated standardized template so that software developers can create tools for consumers to better access this information. We support such a proposal and believe it would help increase transparency on plan information.

CMS acknowledges the work on network adequacy currently underway by the National Association of Insurance Commissioners (NAIC), which released a draft model act last month, and notes that it will await the NAIC's final model act before proposing significant changes in its requirements. The AMA has been working very closely with the NAIC and has submitted extensive comments on the draft model bill. Interested stakeholders representing hospitals, physicians, and other health care providers serving children and adults, as well as health care consumers, signed onto a letter drafted by the AMA and the Children's Hospital Association that was sent to the NAIC in November (see attached copy). We believe that this letter can help inform future policy development by CMS. The letter sets forth the following key principles:

- Provider networks must include a full range of primary, specialty, and subspecialty providers for children and adults to ensure that consumers have access to all covered services, at every level of complexity, without administrative or cost barriers;
- Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards;
- Appeals processes must be fair, timely, transparent and rarely needed. Appeals and other out-of-network arrangements must not be used as an alternative to an adequate network for all covered services;
- The use of tiered provider networks and formularies must be regulated to ensure that consumers of all ages have access to all covered services, including specialty services, without additional cost sharing or administrative burdens;
- Insurers must be unequivocally transparent in provider selection standards; and
- Provider directories must be accurate, up-to-date and easily accessible.

The ACA requires that a QHP's networks include essential community providers (ECPs), where available, that serve predominantly low-income and medically-underserved populations. CMS proposes to strengthen the requirements related to ECPs, adding as ECPs state-owned, government, and not-for-

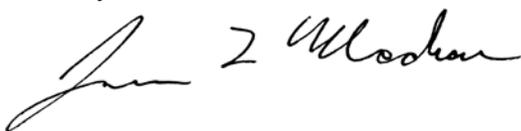
profit facilities, including family planning service sites, regardless of whether they receive federal funding under specific federal programs. QHPs must include a specified percentage, to be provided in future guidance, of available ECPs; all available Indian health providers in their service area; and at least one ECP in each ECP category in each county in the service area where an ECP is available. Moreover, QHPs that do not meet these standards must offer a narrative justification providing a thorough explanation of why good faith efforts to contract with an ECP failed and what contingency plans the QHP has for providing ECP services. QHPs that provide a majority of their services through employees or a single contracted medical group may meet an alternative standard for providing services to low-income and medically underserved enrollees. The AMA supports these proposals. However, one area that we believe CMS might consider addressing is whether children's hospitals, which are considered to be ECPs but are lumped in with other kinds of hospitals as an ECP category, should be separated out as their own category. Access to children's hospitals, which are uniquely suited to meet the needs of children with complex medical conditions, has been a significant issue over the past year, and the NAIC has been looking closely at this in the context of network adequacy.

Requirements for "Minimum Value" Coverage (§ 156.145)

We support the proposed requirement that group health plans must cover substantial hospitalization and physician services to meet the minimum value requirement under the ACA. Some employers have reportedly offered plans that do not cover inpatient hospital care but still met the minimum value calculator requirements. AMA policy supports using federal guidelines, such as those under the Federal Employee Health Benefits Plan (FEHBP), as a standard for assessing meaningful health insurance coverage for adults. Under the FEHBP, hospitalization and physician services are typically covered.

The AMA appreciates this opportunity to submit comments and looks forward to continuing to work with CMS in improving health insurance coverage under the ACA.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD

Attachment

November 16, 2014

The Honorable Sandy Praeger
Commissioner
Kansas Department of Insurance
420 SW 9th Street
Topeka, Kansas 66612-1678

The Honorable Theodore K. Nickel
Commissioner
Office of the Commissioner of Insurance
State of Wisconsin
125 South Webster Street
Madison, Wisconsin 53707-7873

Dear Commissioners Praeger and Nickel:

The undersigned organizations representing hospitals, physicians, and other health care providers serving both children and adults, as well as health care consumers and other stakeholders, wish to thank you for the opportunity to provide the perspective of our members on the development of meaningful standards for network adequacy. As the National Association of Insurance Commissioners (NAIC) continues the process to revise its 1996 Managed Care Plan Network Adequacy Act (Model Act #74), we have joined together to make the following recommendations. We believe that these issues must be addressed in the final Model Act:

- Provider networks must include a full range of primary, specialty and subspecialty providers for children and adults to ensure that consumers have access to all covered services, at every level of complexity, without administrative or cost barriers;
- Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards;
- Appeals processes must be fair, timely, transparent and rarely needed. Appeals and other out-of-network arrangements must not be used as an alternative to an adequate network for all covered services;
- The use of tiered provider networks and formularies must be regulated to ensure that consumers of all ages have access to all covered services, including specialty services, without additional cost sharing or administrative burdens;
- Insurers must be unequivocally transparent in provider selection standards; and
- Provider directories must be accurate, up-to-date and easily accessible.

We recognize that there already is broad regulator support for these concepts, and we appreciate that the NAIC has been deliberative in hearing from all interested parties. By adopting provisions consistent with the principles outlined in this letter, we believe lawmakers and regulators can adapt the Model Act to establish reasonable, meaningful standards, while still allowing for market flexibility and choice.

1. Provider networks must include a full range of primary, specialty and subspecialty providers for all covered services for children and adults.

Health plans must be able to demonstrate that their enrollees have access to a full range of pediatric and adult providers for all covered services, from primary care to specialty and subspecialty providers for complex medical needs. To ensure that plans fulfill their obligations to cover their beneficiaries and are not discriminating based on health status, the Model Act must include provisions that:

- Require all health plan networks to include providers that deliver high-quality wellness and prevention care, care for episodic illness, a full spectrum of post-acute care services, management of chronic conditions, and advance illness care for both children and adults. Inadequate and limited networks that do not include this range of providers may result in care delays with poor medical outcomes that ultimately cost insurers and consumers more.
- Provider networks must be evaluated for their capacity to address the needs of covered persons who may face barriers to access to care, including but not limited to children and adults with serious, complex or chronic medical conditions; and individuals with limited English proficiency and illiteracy, diverse cultural and ethnic backgrounds, and physical and mental disabilities.
- An emphasis must be placed on ensuring that consumers have access to care provided by all types of essential community providers, a medical home that can coordinate care, behavioral health services, and hospital-based care to meet specific needs, including but not limited to academic medical centers, children's hospitals, oncology centers, and transplant centers.
- Children and adults with complex and chronic medical needs must be provided access to a choice of in-network specialists and subspecialists, as well as appropriate community and specialty facilities, for the treatment of their medical and behavioral health conditions. As detailed elsewhere in this letter, reliance on appeals, grievance or other processes to account for access to specialty care reflects an inadequate network.

2. Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards

Determinations of network adequacy must be the responsibility of regulators, utilizing strong quantitative and objective measures that take into consideration geographic challenges and the entire range of consumers' health care needs. Quantitative network measures will require state regulators to more effectively evaluate, monitor, and enforce insurers' networks to protect consumers, and eliminate dependence on insurer self-attestation or third-party certification regarding network adequacy.

We urge the NAIC to incorporate into the Model Act the types of quantitative measurements to be used, but allow regulators to adapt specific thresholds reasonable for their state. For example, the use of commonly used distance standards would not be an appropriate measure of a network's adequacy for children in need of the tertiary and quaternary specialty care provided by a children's hospital. In fact, if those standards are the sole determinant of a network's adequacy, almost half of all children would not have access to the specialty care provided through a children's hospital given the regional nature of that care.¹

Therefore, it is imperative that the Model Act include provisions that call for the use of a broad set of quantitative measures, as no individual measurement is likely to ensure access, and in fact, if used alone, may provide a false assessment of adequacy.

Among the quantitative measures that should be delineated in the Model Act are the following:

- Maximum travel time and distance, with appropriate adjustments for geographic differences and for the regionalization of specialty care to assure access to all covered services;
- Maximum appointment wait times;
- Provider capacity and admitting of new patients;
- Minimum providers available to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, physical and mental disabilities, and children and adults with complex medical conditions;
- Provider hours and availability;
- Availability of technological, diagnostic and ancillary services; and
- Patient feedback, as well as issuer documentation of, network access, particularly for children and adults with complex and chronic conditions.

It is important to note that quantitative standards do not diminish the need for regulators to individually assess networks that may employ unique techniques to ensure access to care that

¹ Analysis by the Children's Hospital Association, November 2014.

may fall outside the established objective requirements. For instance, as noted above, there may not be specific specialty care available within the required time and distance standards. However, if the insurer has arranged for access to that specialized care outside the geographic region, the regulator should still consider approval of the network.

We also wish to highlight the importance of the use of quality measurement, as well as patient feedback through regular consumer surveys and consumer complaints, in the evaluation of network adequacy. Finally, ensuring access to care and establishing consumer protections starts with having standards that are applied fairly and consistently on all insurers.

3. Appeals processes must be fair, timely, transparent and rarely needed

The Model Act must make clear that out-of-network arrangements and procedures are not an acceptable alternative to plans having an adequate network. Our organizations are extremely concerned about a reliance on appeals processes and other administrative procedures as a remedy for networks that are so narrow that one must go out-of-network to access covered services. Furthermore, we believe that the best way to ensure patients' access to care is to establish strong network adequacy requirements that meet the needs of both children and adults so that appeals processes are rarely, if ever, needed. A reliance on appeals processes to resolve network inadequacies does not reduce health care costs; instead, they leave consumers at risk of delayed and fragmented care and providers with additional administrative costs, all of which increase the overall costs of care.

Therefore, we urge the NAIC to consider and adopt the following requirements:

- All networks should meet or exceed network adequacy requirements and provide consumers access to all covered services.
- When out-of-network care is received because there is no provider in-network capable of providing a covered service, cost-sharing and other plan requirements for the consumer should be the same as if the provider was contracted and in-network. In addition, the insurer must take immediate steps to remedy the gaps in the network.
- In instances when an in-network provider is not available, plans should demonstrate that they maintain an adequate and timely approval process for out-of-network services, utilize appropriate clinical standards in evaluating requests, and have an appeals process for denied services.

Finally, we recognize the need for insurers to have the requisite flexibility to incent physicians, hospitals and other health care providers and facilities to contract in good faith. We are concerned, however, that permitting insurers to pay non-contracted providers deeply discounted, non-negotiated rates to remedy inadequate networks will not protect consumers. In fact, this practice may have the unintended consequence of encouraging insurers to create inadequate networks in the first place. Therefore, when there is an inadequate network, we believe that payers should be required to reimburse providers the reasonable and customary value for out-of-

network services. This both protects the patient and helps ensure a level playing field during contract negotiations.

4. The use of tiered and narrow provider networks and formularies must be regulated

Specific patient protections must be included in the Model Act for networks that are tiered or are limited in scope and number of providers in order to prevent unfair discrimination based on health status. The selection criteria utilized by health carriers for participation in these more restricted or narrow networks must consider the quality of the health services provided and the ability of the in-network providers to deliver all necessary covered services, including specialty and subspecialty care. In particular, narrow and tiered networks must not be designed solely on the basis of cost and must not impede the provision of timely and high quality care, especially for children and adults with complex medical conditions.

As you know, in a tiered network design, providers are placed into tiers and consumer cost-sharing progressively increases when the selected provider is in a higher tier. The increases in cost-sharing between network tiers are often dramatic and can have a negative impact on patients. Similarly, if a network plan's drug formulary is constructed in such a way as to place needed specialty medications and services in the highest tiers, consumers will suffer a large financial burden and may delay the purchase of needed drugs and follow-up care. As a result, tiered formularies can result in reduced medication adherence, worsening health conditions, and higher costs.

To address these concerns, we urge inclusion of the following requirements in the Model Act to ensure that tiering and other types of network and formulary designs do not impede access to timely and quality medical care:

- Network adequacy standards should apply to the lowest cost-sharing tier of any tiered network. That tier must include the full range of specialty care providers for all covered services, including children's hospitals, cancer hospitals, and a range of specialists and subspecialists. The widely understood objective of cost-sharing is to encourage certain consumer decisions. But if there are not enough providers – both primary and specialty care for children and adults – available in the lowest cost-sharing tier, the additional cost-sharing associated with providers in a higher tier is simply an unfair and costly consumer penalty.
- There must be clear consumer information regarding provider networks and formularies that are tiered, including information about cost-sharing responsibilities associated with each tier, and appeals processes. Consumer information is absolutely critical to informed decision-making and out-of-pocket expenses that may be incurred as a result of those decisions. This consumer information must be provided during plan selection to enable individuals and families with specific health care needs to choose the most appropriate plan to meet those needs. There must also be stringent oversight and intervention by regulators when tiers are designed in such a manner as to effectively deny consumers the

value of the premium they have paid and coverage for all benefits promised under the plan.

- A tiered or narrow network may also include integrated/coordinated delivery systems, modeled after accountable care organizations, made up of providers and facilities that coordinate primary and specialty care. The use of an integrated delivery system as part of a tiered network does not relieve the health carrier from its responsibility to provide access to medically necessary covered services not otherwise available from the integrated delivery system. That care may include specialty care for children and adults who have complex medical conditions, such as pediatric specialty services, specialized cancer treatment, tertiary and quaternary care, as well as psychiatric and substance abuse treatment.
- The Model Act must protect consumers from higher cost-sharing when their current provider is switched from one tier to another. This should be recognized as a continuity of care issue, given that movement of a provider among tiers can have a significant impact on the important patient-provider relationship and the patient's ability to continue with ongoing care.

5. Insurers must be transparent in the design of their provider networks

It is critical that consumers have clear information regarding the design of their plan's provider network. Therefore, the Model Act must include provisions that require transparency in network design and oversight mechanisms to ensure compliance.

First, full transparency of issuers' provider selection standards is critical, given the shift toward narrow and tiered networks, many of which seem to be designed on the basis of cost, rather than quality. The tiering of certain specialty providers into higher cost tiers or the exclusion of those providers from a network is problematic because it could place unanticipated costs onto patients enrolled in the plan or deter patients with serious medical needs from that plan or product. Not only do those plans run the risk of being insufficient for children and adults with specialized health care needs, but they may also violate non-discrimination protections.

Second, issuers may identify networks that exclude specialty providers as "high-value" or "high-performing," and, thus, imply that provider quality has been considered in the development of the network. In the event that quality is a factor that is used in the design of a network, consumers and providers should have information regarding the quality measures that were used. By the same token, if quality measures have not been used to create the network, it is critical that consumers, providers and regulators are made aware of the basic methods that were used to create the network, which may be centered on lower-cost providers.

6. Provider directories must be accurate and up-to-date

We agree with the NAIC network adequacy task force that consumers must have access to robust, up-to-date provider directories to enable them to determine which providers are in-network when they purchase their plans, and, in the event their medical needs change, when they need new providers. Furthermore, providers need accurate information from health plans to allow for in-network referrals when further, specialized treatment is warranted.

Provider directories should provide as much detail as possible about network providers including, but not limited to:

- Name, address, county, office telephone number, and Web site address or other link to more detailed individual provider information, if available;
- Hours of operation;
- If the network is tiered, a conspicuous disclaimer indicating which tier the provider is in, how that provider tier impacts consumer's financial or other obligations, and any appeals or prior authorizations processes;
- Listings of hospitals by type (e.g. general acute care, children's, cancer, orthopedic, rehab);
- Specialty and/or subspecialty information;
- Whether the provider is accepting new patients;
- Names and locations of the hospital(s) where the physician or other provider has medical staff privileges and whether those hospitals are part of the provider network;
- Indication of whether the physician may be selected as a primary care physician; and
- Generally accepted and appropriate quality measures, if used by the insurer.

Updates to online directories should be made in a timely fashion. Moreover, it is critically important that regulators monitor the accuracy of provider directories on an ongoing basis and especially at open enrollment. The impact of inaccurate provider directories on consumers can be devastating, especially on those consumers who need to carefully examine networks for specific subspecialists, cancer centers, children's hospitals, etc.

Finally, we want to emphasize that transparency in directories and up-to-date information on providers is not a substitute for a robust network that allows access to all covered services for both children and adults. Rather, transparent and accurate consumer information should be used as a means to educate consumers about the full scope and limits of a provider network so they have meaningful access to the care they need when they need it.

Conclusion

Our organizations are committed to working with you to strengthen the NAIC Model Act #74 to ensure that all consumers have timely access to covered services, regardless of the complexity of their needs. We appreciate your continued attention to the priorities of our organizations and the consumers we serve.

Sincerely,

Alliance of Dedicated Cancer Centers
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pediatrics
American Association for Marriage and Family Therapy
American Association of Neurological Surgeons
American College of Emergency Physicians
American College of Phlebology
American College of Physicians
American College of Radiology
American College of Rheumatology
American Health Care Association/National Center for Assisted Living
American Group Psychotherapy Association
American Medical Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Optometric Association
American Osteopathic Association
American Psychiatric Association
American Psychological Association
American Society for Dermatologic Surgery Association
American Society for Surgery of the Hand
American Society for Reproductive Medicine
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Echocardiography
American Society of Interventional Pain Physicians
American Society of Neuroradiology
American Society of Transplant Surgeons

American Speech-Language-Hearing Association
American Telemedicine Association
American Therapeutic Recreation Association
American Thoracic Society
American Urological Association
Association for Ambulatory Behavioral Healthcare
Cancer Support Community
Children and Adults with Attention Deficit/Hyperactivity Disorders
Children's Hospital Association
Children Now
Children's Partnership
College of American Pathologists
Colorado Medical Society
Congress of Neurological Surgeons
Connecticut State Medical Society
Family Voices
First Focus
Easter Seals
Epilepsy Foundation
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Kidney Care Council
Leukemia & Lymphoma Society
Maine Medical Association
Massachusetts Medical Society
MedCHI, The Maryland State Medical Society
Medical Association of Georgia
Medical Association of the State of Alabama
Medical Group Management Association
Medical Society of Delaware
Medical Society of the District of Columbia
Medical Society of New Jersey
Medical Society of the State of New York
Medical Society of Virginia
Mental Health America
Michigan State Medical Society
Minnesota Medical Association
Mississippi Ambulatory Surgery Center Association
Mississippi State Medical Association
Missouri State Medical Association

Montana Medical Association
National Alliance to Advance Adolescent Health
National Association of Medical Examiners
National Alliance on Mental Illness
National Association of School Nurses
National Association of State Mental Health Program Directors
National Council for Behavioral Health
National Marrow Donor Program-Be The Match
Nebraska Medical Association
Nevada State Medical Association
New Mexico Medical Society
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Parity Implementation Coalition
Pediatric Congenital Heart Association
Pennsylvania Medical Society
Physicians Advocacy Institute, Inc.
Rhode Island Medical Society
Society for Cardiovascular Angiography and Interventions
Society of Critical Care Medicine
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
United Cerebral Palsy
United Spinal Association
Vermont Medical Society
Washington State Medical Association
Wisconsin Medical Society

cc: Members of the NAIC Health Insurance and Managed Care (B) Committee
Members of the NAIC Regulatory Framework (B) Task Force
Members of the NAIC Network Adequacy Model Review Subgroup
Jolie Matthews, Senior Health Policy Advisor and Counsel, NAIC