



December 22, 2014

Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-9944-P  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue SW  
Washington, DC 20201

Re: Proposed Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P).

Dear Administrator Tavenner,

The American College of Physicians (ACP) appreciates the opportunity to comment on the Proposed Rule: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016. The [American College of Physicians](#) is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 141,000 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.

ACP appreciates the work and dedication of Secretary Burwell, the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), and other relevant agencies in their efforts to implement the Affordable Care Act. The proposed rule marks an important progression in improving the accuracy of provider network information, ensuring objectivity in the development of prescription drug formularies, and improving the prescription drug exception process. ACP respectfully offers the following commentary and recommendations:

#### 155.355: Annual Eligibility Redetermination

While it is sensible to encourage qualified health plan (QHP) enrollees to shop around for the plan that best meets their insurance needs and financial situation, ACP is concerned that automatically transferring an enrollee to a cheaper plan could create problems. A lower-cost plan could have a narrow provider network and not include an enrollee's preferred physician or hospital. While premiums may be

lower, deductibles, coinsurance, and copayments may be higher than in the enrollee's previous plan. Formularies may also differ. Many health insurance consumers have limited health insurance literacy and abruptly switching a person to a new plan with a different structure could be very confusing. While the price of health insurance is important, consumers value other health plan characteristics, including provider networks. The College urges caution in implementing automatic re-enrollment policies, even if an enrollee chooses the lowest cost plan re-enrollment option. If the agency pursues this option, efforts should be made to educate the enrollee in advance of default re-enrollment on potential changes to plan structure, cost-sharing, provider networks, and formularies, and highlight the opportunity to switch plans during open enrollment if they prefer.

#### 155.420: Special Enrollment Periods

ACP reiterates our recommendation<sup>2</sup> that a special enrollment period be triggered 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. We ask the agency to clarify if this would be permitted under 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."

#### 156.115: Provision of EHB

ACP supports the proposal to allow states to update their benchmark plans as well as the requirement to collect and report essential health benefit data. ACP strongly supports a robust essential health benefit package that includes prevention and wellness services and chronic disease management. We urge CMS to work with states to gather data and guide QHPs to ensure they provide coverage proven to be effective in reducing obesity, stopping smoking, deterring alcohol abuse, and promoting wellness, among other goals. We continue to support requirements that QHPs cover preventive services without cost sharing, including those supported by the United States Preventive Services Task Force.

#### 156.122: Prescription Drug Benefits

ACP is supportive of the agency's proposal to improve oversight of QHP prescription drug benefits and ensure that enrollees can access safe and effective medications. Although the College does not have policy on the existing US Pharmacopeia (USP) drug count system, we are concerned that current requirements are insufficient and unwieldy for patients, physicians and other health care professionals, and issuers. Requiring QHPs to establish objective pharmacy and therapeutic (P&T) committees that include practicing physicians (such as internists) among the membership will help to ensure that QHPs make formulary decisions based on a drug's safety and efficacy, not just its cost and facilitate consideration of new FDA-approved drugs as well as new uses of existing drugs. At a minimum, an improved drug count requirement working in concert with the P&T committee recommendations could relieve concern about the existing formulary requirements. ACP provides the following guidelines on formulary development:

- ACP opposes any formulary that may operate to the detriment of patient care, such as those developed primarily to control costs.
- Decisions about which drugs are chosen for formulary inclusion should be based upon the drug's effectiveness, safety, and ease of administration rather than solely based on cost.
- Evaluation of physician prescribing patterns (i.e., drug utilization review) should give priority to the effectiveness, safety, and ease of administration of the drugs prescribed rather than solely based on costs.
- ACP recommends that formularies should be constructed so that physicians have the option of prescribing drugs that are not on the formulary (based on objective data to support a justifiable, medically indicated cause) without cumbersome prior authorization requirements.
- Patient formulary education should include how the formulary functions, and a discussion of how co-payment and/or deductible requirements may affect their pharmacy benefit.
- ACP supports prompt prior notification to patients and physicians when formularies are changed or discontinued.
- ACP recommends such notification be given within a specified time period, not fewer than ninety (90) days prior to change implementation.
- ACP recommends that Pharmacy & Therapeutic (P&T) Committees be representative of, and have the support of, the medical staffs that will utilize the formulary.

ACP believes that there must be a process for expedited prescription drug coverage exceptions and appeals. The final rule should mandate that insurers and independent review entities provide a decision to the patient and provider, prescriber, etc. within 24 hours for exigent health situations or 72 hours for non-exigent situations. The College applauds the proposed standard exception process (156.122(c)(1)) for disputed prescription drugs as well as the expedited exceptions process for exigent circumstances. These changes will help to ensure our patients can receive necessary drugs prescribed by their physicians without delay. QHPs 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.

#### 156.125: Prohibition on Discrimination

ACP is very concerned that some QHPs are designing plans that may discriminate against some patients, including those with multiple chronic health conditions. We urge that federal and state regulators and other stakeholders 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.

The College appreciates that the proposed rule acknowledges this concern and admonishes issuers to design plans that reflect the non-discrimination requirements of the law. We support language that would prevent the discriminatory age limits on effective benefits as well as prohibitions on plan designs that would discourage enrollment of patients with chronic health needs. Moreover, we strongly urge CMS to enforce non-discrimination requirements.

#### 156.145: Determination of Minimal Value

ACP supports this provision, which would codify the requirement that employer-sponsored plans must provide coverage of inpatient hospitalization and physician services to meet minimum value requirements. This policy will ensure that enrollees can access crucial services that form the core of health insurance plans.

#### 156.230: Network Adequacy

ACP remains concerned that many QHPs continue to offer narrow network (including tiered network plans) in an effort to hold down costs. The College acknowledges that in the 2015 letter to federally-facilitated marketplace issuers<sup>1</sup>, CMS outlined its intent to assess provider networks using a “reasonable access” standard, identify plans that fail to meet this standard, and apply particular scrutiny to areas that have historically raised network adequacy concerns, including primary care providers. The rule proposes continuing this standard in the 2016 plan year while acknowledging that the National Association of Insurance Commissioners (NAIC) is in the process of updating its Managed Care Plan Network Adequacy Model Act (Model Act). Since the NAIC’s updated Model Act may recommend significant changes, ACP requests that, in its final rule, CMS outline a schedule for considering and, if necessary, updating the network adequacy standards based on the revised NAIC Model Act.

ACP reiterates its recommendations to HHS<sup>2</sup> on network adequacy standards, including:

- That CMS improve current network adequacy standards by taking into account additional quantitative criteria—including patient-to-physician ratios, maximum travel time and distance, and provider capacity standards—as indicators of access. CMS should 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).
- Continuously monitor network adequacy by complaint tracking and random spot checks of QHP network data.<sup>3</sup> We recommend that such compliance and complaint information be made available to the public.
- Require transparency in the criteria used by QHPs to determine who will be allowed into networks. 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 whose practices contain substantial numbers of patients with expensive medical conditions.

- Network adequacy requirements should be strictly enforced.

ACP supports the proposed rule's requirement that provider directories be up-to-date, accurate, complete, and, at a minimum, include the provider information specified in the rule. Online provider directories should be updated at least monthly. The College reiterates its support for the development of an online search tool to allow federally-facilitated marketplace users to search for QHPs by clinician and hospital name and filter out health plans that do not include the consumer's chosen clinician or hospital in network. Requiring QHP issuers to provide network data in machine-readable format may facilitate the development of such tools by third-party entities; however, this should not substitute the agency's work to develop tools to improve the consumer shopping experience.

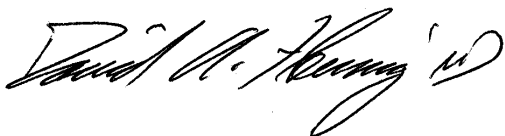
ACP requests adoption of the continuity of care provisions that would allow an out-of-network physician to continue treatment of a patient regardless of network status during the first 30 days following enrollment in a new QHP. ACP supports language that would require issuers to count out-of-network cost-sharing toward the annual out-of-pocket limit. While the language in 156.130 would make this optional, the College requests that at a minimum, out-of-network cost-sharing for care received when appropriate physicians (i.e. subspecialists) or services are not offered in the plan's existing network be applied to the annual limitation on cost sharing.

#### 156.235: Essential Community Providers

The College supports requirements for the inclusion of essential community providers (ECP), such as Federally Qualified Health Centers, Ryan White HIV/AIDS Providers and safety-net hospitals, and maintains that the 30% ECP threshold (established in the 2015 letter to FFM issuers) should be a minimum floor, 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.

Thank you for your consideration. If you have questions, please contact Ryan Crowley, Senior Associate for Health Policy at [rcrowley@acponline.org](mailto:rcrowley@acponline.org).

Sincerely,



David A. Fleming, MD, MA, 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. 2015 Letter to Issuers in the Federally-facilitated Marketplaces. March 14, 2014. Accessed at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>

<sup>2</sup> American College of Physicians. Letter to the Honorable Kathleen Sebelius. February 11, 2014. Accessed at [http://www.acponline.org/acp\\_policy/letters/sebelius\\_letter\\_snhc\\_2014.pdf](http://www.acponline.org/acp_policy/letters/sebelius_letter_snhc_2014.pdf)

<sup>3</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. April 2013.