December 18, 2015

The Honorable Sylvia Burwell
Secretary
U.S. Department of Health and Human Services
ATTN: CMS-9937-P
PO Box 8016
Baltimore, MD 21244-8016

RE: File Code CMS-9937-P (Notice of Benefit and Payment Parameters for 2017)

Dear Secretary Burwell:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 30 million volunteers and supporters, we appreciate this opportunity to submit comments on the Department of Health and Human Services' (HHS) proposed rule, "Notice of Benefit and Payment Parameters for 2017."

The AHA/ASA has long advocated for all Americans to have access to affordable, quality health insurance coverage. Access to affordable, quality health care is critical to helping the association achieve its ambitious goal to prevent as many heart attacks and strokes as possible, as well as to reduce the risk factors for these conditions.

We applaud HHS for addressing a number of concerns that we've raised previously about the issues that patients have using their health insurance coverage, particularly with respect to network adequacy. While more work remains to be done to ensure that the Affordable Care Act (ACA) fully meets the promise of providing affordable, adequate, transparent access to health care, this proposed rule continues to move in the right direction. Although this rule covers many important topics, we have focused our specific comments below on a number of issues that we believe are particularly critical to people with heart disease or stroke or who need to prevent these conditions.

§155.200 – Functions of an Exchange

As part of the general functions of an exchange, HHS is proposing that a state-based exchange using the federal platform (SBE-FP) (i.e. HealthCare.gov) be required to establish and oversee requirements for its qualified health plans (QHPs) and QHP issuers that are no less strict than the existing and proposed standards that apply to federally-facilitated exchange (FFE) plans and issuers. In particular, HHS would require that standards related to the formulary drug list, network adequacy,

meaningful difference, and essential community providers apply to the SBE-FP. We agree with HHS that consumers shopping for coverage on HealthCare.gov in a SBE-FP state should have confidence that the plans available to them have consumer protections that are at least as strong as others available through the HealthCare.gov Marketplace. We also support allowing SBE-FP states to impose stronger standards (for example, stronger network adequacy standards), provided that they don't present display issues for HealthCare.gov.

Exchange Functions in the Individual Market – Medicare Notices

We applaud HHS for recognizing the importance of providing notification to enrollees in coverage through the exchange of their potential eligibility for Medicare and for seeking comment on whether and how to implement a notification that an enrollee may have become eligible for Medicare. Many enrollees in exchange coverage are not aware that their eligibility for the health insurance premium tax credit ends when they become eligible for Medicare. In addition, individuals who do not enroll in Medicare when they become eligible may face significant consequences, including lifetime premium penalties and delays in access to essential low-income benefits and gaps.

Given the potential severe consequences of delaying enrollment in Medicare, it is unfortunate that there is no official federal communication to older adults or the disabled that informs them about when and how to enroll in Medicare or what may result from delayed enrollment, nor is there any trigger to spur the individual to seek out this information. Therefore, we believe that it is critically important that exchanges play a role in helping inform consumers who are potentially eligible for Medicare of their coverage options. HHS's proposal for "pop up" text on HealthCare.gov for potential enrollees who are going to turn 65 during the benefit year would be a helpful step in the right direction, but we don't believe that alone is sufficient. We urge CMS to develop a comprehensive screening and notification system that helps enrollees successfully make the transition from Marketplace coverage to Medicare. We further commend to you the more specific recommendations being put forward by the Medicare Rights Center and other groups, including the AHA/ASA, with a strong interest in ensuring that individuals and families are enrolled in the coverage that will best meet their needs.

§155.420 – Special Enrollment Periods

HHS indicates that it heard concerns that special enrollment periods (SEPs) may be subject to abuse. We remind HHS that each of the SEPs was created to address specific, real situations that consumers may face during the year that may cause them to lose coverage or need to switch coverage, such as a loss of minimum essential coverage, moving, or getting married or divorced, to name a few. We encourage HHS not to eliminate any SEPs in the absence of proof that they are indeed being misused.

§155.1000 – Certification Standards for QHPs

We commend HHS for indicating that it could increasingly use its authority to deny certification of QHPs that meet the minimum standards but are not in the "interests of qualified individuals and qualified employers." We believe this move toward more active purchasing can promote the availability of high-value health plans. The ultimate goal of making affordable health coverage available to individuals and employers can be best

achieved by FFEs acting in a balanced role as an active purchaser using their authority to only offer plans that enhance value, consumer protection and affordability. The FFEs should use their certification authority to promote innovative health care delivery system reforms that hold promise for slowing the rate of growth in health care costs by requiring or encouraging insurers to incorporate such measures. The FFEs could also promote a strong foundation of well-coordinated, primary care.

§156.20 – Standardized Options

We also support HHS's proposal to develop plans with standardized cost-sharing and other features, but urge HHS to go a step further by requiring issuers to offer a standardized plan for every metal level for which they're offering a non-standardized plan. In general, we agree that standardized options can be beneficial to consumers in a number of ways, but only if they are actually available. Seven SBEs require standardized benefits for 2016, and such a requirement would also be beneficial in the FFEs.

Standardized options make it easier for consumers to shop for coverage. By standardizing the cost-sharing, consumers can compare plans based on a limited number of other factors, such as whether their providers are in-network, which issuer has the best premium, and which issuer provides high-quality service. As experience with Medicare Part D, Medicare Advantage, Medicare supplemental plans, and Healthcare.gov has illustrated, consumers find a large number of cost-sharing structures overwhelming. In addition, the standardized plan options proposed address another significant consumer concern, high deductibles. Research has shown that consumers with high-deductible plans often forego needed care due to the cost. By exempting primary care visits, specialist visits, urgent care visits, and prescription drugs from the deductible in the standardized plans, consumers will be able to afford important care even if they haven't yet met their deductible.

We generally support the elements of the standardized options proposed by HHS, but offer the following recommendations:

- Drug formularies: Formularies would have four drug tiers— generic, preferred brand, non-preferred brand, and specialty drug tiers. While we would support allowing issuers to use value-based insurance design (i.e. waiving co-payments for medications for chronic conditions such as hypertension and diabetes) as a means of encouraging medication adherence, allowing issuers to add an additional lower-cost drug tier (which presumably would be a non-preferred generic tier) would undermine the benefits of the standardized options.
- Provider tiers: Provider networks would have only one tier, as is currently the case for the vast majority of enrollees in FFE QHPs. Given the potential for discriminatory design in tiered provider networks, we strongly support single-tiered networks.
- Deductible-exempt services: As noted above, exempting certain routine services from the deductible would be very beneficial to consumers and would help to ensure that patients don't forego needed services that could result in the need for more expensive, complicated care later. In addition to exempting primary and specialty care office visits, prescription drugs, and mental/behavioral health and

substance use outpatient services from the deductible, we strongly urge HHS to consider exempting rehabilitative and habilitative outpatient services from the deductible. Such services can be very helpful to patients recovering from a cardiac event or stroke but applying the deductible, in addition to co-payments or co-insurance, can make this care unaffordable. Given that these services are often utilized after an inpatient hospital stay (which would likely result in enrollees having met their deductible anyway), we believe that explicitly exempting rehabilitative and habilitative care from the deductible can be done with very little impact on a plan's actuarial value.

- The proposed coinsurance for the specialty tier for Silver plans is overly burdensome and must be lowered to be more in line with other cost sharing. According to an Avalere Health analysis of 2015 QHP data, less than half of silver plans have specialty tier coinsurance of more than 30 percent.[1] Instead of the 40 percent coinsurance that was proposed, CMS should consider switching to a copayment for the specialty tier. Copayments are more transparent and make it easier for consumers to predict their out-of-pocket costs. Co-insurance percentages are often meaningless to patients since they have no way of knowing how the percentage translates to how much they will have to pay for a drug.

§156.122 – Prescription Drug Benefits

We strongly supported HHS's implementation for the 2016 plan year of specific timeframes by which plans must provide for external review of denied "exceptions process" requests from enrollees needing to gain access to clinically appropriate drugs that are not covered by the plan's formulary. Under this provision, most individual and small group health plans are required to meet a 72-hour deadline for external review of a denied exception (or 24 hours for urgent requests). Now, however, HHS indicates that it is considering amending this provision to allow a state that has appeals laws or regulations that are "more stringent than or are in conflict with our exceptions process" to satisfy the review requirements. Given that under the 2010 appeals regulation, plans have 45 days to conduct external review (or 72 hours for urgent claims) for adverse coverage determinations, it appears that the practical implication of this proposal is that individuals who get exceptions denials reviewed within 72 hours in 2016 would have to wait considerably longer for a decision in 2017. It is not clear whether, if a state law permits more than 72 hours for an external review, and in some cases up to 75 days, that would be "in conflict with" the 2016 regulation. We urge HHS to continue to require that plans meet the current exceptions process for off-formulary medicines and not permit them to use the longer appeals processes.

§156.230 – Network Adequacy Standards

In general, we applaud HHS for recognizing the need to strengthen network adequacy standards and for proposing a number of new protections that would apply for the 2017 plan year. While millions of Americans have gained health insurance over the last two years, that coverage is unfortunately hollow if they cannot access the covered benefits

[1] Avalere Health, "Exchange Plans Increase Costs of Specialty Drugs for Patients in 2015," Dec. 3, 2014.

promised to them. Even though the National Association of Insurance Commissioners (NAIC) has now completed its work on its updated Health Benefit Plan Network Access and Adequacy Model Act (Model Act), it is not yet clear how many states will adopt it in whole or in part. Therefore, we strongly encourage HHS to move forward with strong network adequacy standards that can serve as a floor of protection for consumers enrolled in QHPs beginning in 2017.

We offer the following specific comments and recommendations with respect to HHS's proposed network adequacy requirements.

Minimum Threshold

HHS is proposing to rely on FFE states to review QHPs for network adequacy, using quantitative time and distance and provider-enrollee standards determined by the states. In those FFE states that do not either review for network adequacy or set minimum quantitative standards, HHS would conduct the review using a federal default time and distance standard. HHS indicates that it will provide more details on the specific criteria and process for meeting the standard in the annual Letter to Issuers. We look forward to reviewing the default standards in the 2017 draft Letter to Issuers.

We strongly support requiring an affirmative review of QHPs, using a set of minimum quantitative standards. In fact, we note that the statute as well as section 156.230(a)(2) of the federal regulations requires all issuers offering QHPs to maintain a network that is sufficient in number and types of providers to assure that all covered services are accessible without unreasonable delay. We therefore believe that the final rule should be revised to require all states, including those with SBEs, to conduct network adequacy reviews of QHPs using a minimum set of quantitative standards. A number of states with SBEs do not currently use quantitative standards for evaluating network sufficiency.

It is critical, especially in this changing health care environment with rapidly evolving network designs, that regulators actively seek to identify and address network adequacy problems within a plan's network ***before*** the product is ever sold to and relied upon by consumers. In addition, without measurable criteria, insurers and regulators within a state may have very different interpretations of what is sufficient. Such subjectivity would make it difficult for both regulators and consumers to argue that a given network is inadequate.

HHS seeks comments about using county-level time and distance standards, similar to those used in Medicare Advantage (MA). We point out that MA requires the use of minimum provider and facility ratios, in addition to minimum time and distance standards. Therefore, we recommend that HHS also incorporate minimum provider/facility ratios in its standards for QHPs. In general, we believe that the MA standards, with their five geographic categories (large metro, metropolitan, micro-metropolitan, rural and Counties with Extreme Access Considerations (CEAC)) that account for geographic variations in provider accessibility and population distribution, would serve as an appropriate basis for QHP federal default standards.

However, it would be very important to supplement the MA standards to account for differences between Medicare plans and QHPs in the covered population and covered services. For example, MA plans typically do not include children and are not required to

cover dental services. In particular, children are a special population requiring special consideration because the providers of their care are different than those for adults and applying the MA standards to specialty pediatric providers would not be appropriate. Children and youth with special health care needs, such as those born with congenital heart defects, must have access to pediatric specialty and subspecialty care, such as that provided by pediatric subspecialists, pediatric surgical specialists, and children's hospitals, in order to address their particular health and developmental conditions. A strong pediatric network adequacy standard, as well as a robust process for the review of issuer compliance with that standard, is critical to their care and well-being. Therefore, the quantitative standards used for QHPs would need to be supplemented, for example, to include pediatric primary and specialty care providers and, for stand-alone dental plans, dental providers.

In addition, regardless of what quantitative standards are used, it is important that there be a robust review process to ensure that insurers are complying, including a greater focus on the sufficient inclusion of specific types of providers, including specialists. While we understand that CMS has focused previous reviews on 5 provider types (hospital systems, mental health providers, oncology providers, primary care providers, and dental providers, if applicable), other categories of providers warrant greater scrutiny. As evidence of this, a recent study published in the *Journal of the American Medical Association* found that 13 percent of QHPs sampled completely lacked an in-network specialist within a 100-mile radius for at least one medical specialty. While rheumatologists, psychiatrists, and endocrinologists were most likely to be excluded from networks, the researchers found at least one plan where not a single cardiologist or neurologist was available in-network within 100 miles.[2]

We particularly recommend that CMS look closely at hospital-based physicians at in-network hospitals to ensure that the network includes a sufficient number of such physicians, especially emergency department doctors, anesthesiologists, and radiologists. Many consumers assume that the hospital-based physicians who care for them at an in-network hospital are also in their plan's network. However, analysis of data from Texas PPO plans by the Center for Public Policy Priorities found that for two of the largest insurers in the state, 48 percent and 56 percent of their in-network hospitals, respectively, had not a single in-network Emergency Department physician. One insurer in particular also reported that 38 percent of their in-network hospitals had no in-network anesthesiologists and 31 percent had no in-network radiologists.[3] This leaves consumers vulnerable to balance billing and we find this unacceptable.

HHS is also seeking comment on the addition of an appointment wait time standard. Such a standard can be a helpful indication of whether a plan's network includes providers with sufficient capacity to provide needed care without unreasonable delay, including sufficient providers that are accepting new patients. We note that 11 states currently have wait time standards that apply to at least certain types of QHPs.[4] In

---

[2] Dorner SC, Jacobs DB, and Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015; 314:1749-1750.

[3] Pogue S, "Surprise Medical Bills Take Advantage of Texans: Little known practice creates a "second emergency" for ER patients," Center for Public Policy Priorities, September 15, 2014. Available at: http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

[4] Giovannelli J, Lucia KW, and Corlette S. "Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks," The Commonwealth Fund, May 2015. Available online at:

addition, the NAIC Model Act includes wait time among the set of criteria that state insurance commissioners can use to determine sufficiency. Therefore, we think it is reasonable to at least give states the option of using wait time among the set of quantitative standards that they are required to use.

When determining network adequacy for QHPs that use a tiered network, we also urge HHS to clarify that only providers in the lowest cost-sharing tier will be counted for purposes of determining network adequacy. Using providers who are assigned to a higher cost-sharing tier can result in significantly more out-of-pocket costs. For example, a study examining hospital choices of consumers enrolled in tiered-network plans in Massachusetts found significant variation in the cost-sharing owed: For each hospital admission, average cost-sharing was $1,070 for non-preferred hospitals, $360 for hospitals in the middle tier, and $170 for preferred hospitals.[5] Given the significant cost impact, consumers should be able to access all covered benefits through providers in the lowest cost-sharing tier without unreasonable travel or delay.

Provider Transitions

We commend HHS for recognizing the need for consumer notification and a transition period when one of their providers is being discontinued from their plan's network. Specifically, HHS proposes requiring QHP issues in all FFEs to notify enrollees about a discontinuation of an in-network provider and ensuring that enrollees have continuity of care protections when a provider is terminated without cause. In general, we support these important consumer protections but again believe they are important enough to warrant applying them to all QHPs, not just those in FFE states. We note that these provisions largely align with what was approved by the NAIC in its Model Act but support their inclusion in the final rule since we don't yet know how many states will adopt the Model Act. We make the following recommendations for improving upon these protections.

With respect to the new notification requirements, HHS requested comments on this proposed provision, including the timeframe for notification, whether separate requirements are needed for primary care providers, and on the appropriate definition of "regular basis." We strongly agree with HHS that it is important for consumers to be notified of changes to their network in a timely manner and support the requirement that issuers make a good faith effort to provide written notice to regular patients of a discontinued provider 30 days prior to the effective date or as soon as practical, regardless of the reason why the provider is leaving the network. From the consumers' perspective, it does not really matter why the provider will no longer be part of the network; it is just important that consumers know that their provider will no longer be part of their network and that they know of their rights to continuing care, if applicable, if in the midst of an active course of treatment. We recommend that "regular basis" be defined as being seen by the provider at least once within the preceding year, rather than leaving this up to insurers' discretion.

---

http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf .

[5] M. B. Frank, J. Hsu, M. B. Landrum et al., "The Impact of a Tiered Network on Hospital Choice," *Health Services Research,* published online Mar. 9, 2015.

We also recommend that *all* patients being seen by a primary care professional be notified when that provider is not continuing in the network, as is required under the NAIC's Model Act and for Medicare Advantage plans. Consumers who are generally healthy may not need to see their primary care provider once a year, but they still need to know when their primary care professional is leaving their network. Finally, HHS should require that these notices to patients include information about enrollees' right to receive transitional care from their provider if they are in the midst of an active course of treatment.

We also applaud HHS for providing for continuity of care protections when patients lose access to a participating provider. We generally support the proposal to require QHP issuers in all FFEs to allow patients in the midst of active treatment to continue treatment until the treatment is complete or for 90 days at in-network cost-sharing rates, although we offer some specific comments and recommendations for improving this provision and ensuring that it provides the intended protection.

First, we recommend that §156.230(e)(2) be revised to make it clear that consumer cost-sharing paid to a provider under this provision also counts toward the maximum out-of-pocket (MOOP) limit and that consumers not be subject to balance billing. This is necessary to ensure that consumers are truly held harmless when they lose access to a provider partway through their plan year, when they have no ability to switch to a different plan.

Quite frankly, we believe that the 90-day transition period should be the minimum, rather than the maximum, length of time for patients being treated for a life-threatening condition, a serious acute condition, pregnancy, or another health condition (such as severe depression or a mental health condition) that would be worsened by discontinuing care by the treating health care provider. We urge HHS to consider a longer transition. We also recommend that patients who have been diagnosed with a terminal illness, defined as a disease or condition that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient within six months, be allowed to continue with their provider until the end-of-life, even though this may extend beyond 90 days. A number of states have included this provision in their continuity of care protections.

We also support providing a continuity of care transition period for new QHP enrollees, as CMS has previously encouraged QHP issuers to permit. Specifically, new enrollees in the midst of an active course of treatment should be able to continue that treatment with their current providers for up to 90 days, even if those providers are not in their new plan's network. Certainly, patients in the midst of treatment for a serious or life-threatening condition have a very strong incentive to seek to enroll in a plan that includes all of their current health care providers. Particularly given the proliferation of narrow networks, however, patients – particularly those with complex conditions – may not be able to find a plan that includes all of the specialists and other providers who treat them. These patients also need a sufficient transition period to allow them to find and make appointments with health care professionals who participate in their new network. We encourage HHS to consider that patients in this situation may not be voluntarily switching plans – that is, they may be switching due to the discontinuation of their current plan.

Finally, we support requiring that requests for continuity of care be subject to the plan's internal and external grievance and appeal processes, as provided for in the NAIC Model Act. We also recommend that non-renewal of a provider's contract be considered a termination without cause for purposes of §156.230(e)(1) and (2). And we support allowing for the use of state standards for continuity of care, when those standards are stronger than the federal standards.

Out-of-Network Cost Sharing

We appreciate that HHS acknowledges the problems faced by consumers when they receive covered services by an out-of-network provider at an in-network facility, often without their knowledge or control. Consumers reasonably expect that by seeking care at an in-network facility, the physicians and other health care professionals providing their care are also in-network. And even when consumers are made aware that this is often not the case, they have very little ability to control which providers care for them. Not unexpectedly, therefore, the "surprise" medical bills that result from out-of-network providers at in-network facilities are a significant cause for consumer complaints and financial hardship. A recent survey by *Consumer Reports* found that 30 percent of privately insured Americans have received a bill where their plan paid much less than they had anticipated.[6]

Unfortunately, however, the remedy being proposed by HHS in §156.230(f) does very little to address the financial harm that consumers experience in these situations and is significantly weaker than the provisions included in the NAIC's Model Act. The most staggering bills that patients face in these situations often are the "balance bills" they receive when out-of-network providers bill consumers for the portion of their charges not paid by the insurer. However, by specifically referring to "cost sharing," our reading of the proposed regulation is that balance billing amounts would not be required to count toward the MOOP limit. The definition of cost sharing at 45 CFR §155.20 specifically excludes balance billing amounts for non-network providers. Moreover, given that the regulatory definition of cost sharing also specifically excludes spending for non-covered services, it appears that this provision would not benefit consumers enrolled in plans with no out-of-network coverage. According to a recent Avalere Health analysis, 62 percent of QHPs available for 2016 are either health maintenance organizations (HMOs) or exclusive provider organizations (EPOs), which typically do not cover out-of-network care.[7] In order to ensure that this provision provides meaningful protection to all consumers enrolled in QHPs, it is critical that HHS revise the final rule to make it clear that balance billed amounts and cost-sharing amounts paid for EHB must be counted toward the MOOP even if the QHP does not otherwise cover out-of-network care.

Having said all of that, the very limited protection proposed is rendered even more futile by allowing insurers to avoid counting *any* costs resulting from care provided by out-of-network providers in in-network facilities toward the MOOP if they simply provide a written notice to the enrollee 10 business days before the provision of care. Notice alone is not sufficient to protect consumers from unfair charges that often result given that,

---

[6] Consumer Reports National Research Center. "Surprise Medical Bills Survey." May 2015, available online at: https://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf.

[7] Avalere Health, "Fewer PPOs Offered on Exchanges in 2016," November 2015, available at: http://avalere-health-production.s3.amazonaws.com/uploads/pdfs/1446739748_20151105_Exchange_Networks_Analysis_FINAL.pdf.

again, consumers have very little ability to control which providers care for them once they have been admitted – all it ensures is that the bill will not be a surprise. The NAIC's Model Act recognizes that notice alone does not address this significant problem that consumers face, which is why it requires consumers to pay only their in-network cost-sharing and holds them financially harmless for charges greater than $500.

In addition, while we do not object to a written notice as long as it is not used as an alternative to providing real financial protection to consumers, the required notice should give consumers meaningful information about the ramifications of being seen by out-of-network providers. Insurers should not be able to meet this requirement with a "form" notice. Rather, the notice should provide consumers with a reasonable estimate of the projected amounts for which the enrollee may be responsible for the specific procedure or condition for which they are being admitted, as well as a list of in-network professionals at the facility. We do, however, applaud HHS for at least recognizing that a notice is not appropriate protection without 10 business days' notice.

Finally, we note that this new provision does nothing to protect consumers from balance billed amounts that are provided in an emergency at out-of-network facilities. While insurers are required to charge in-network cost-sharing rates for emergency services provided at out-of-network facilities, consumers can still be subject to balance bills. Again, given that consumers in an emergency often do not have any control over the facility they are taken to or the providers who treat them, it is particularly unfair that consumers are not protected from these sometimes exorbitant charges. We urge HHS to also provide protection for consumers in this circumstance.

In summary, we make the following recommendations for improving §156.230(f):

- Revise (f)(1) to read: "(1) Count amounts paid by an enrollee, including balance billed amounts, for an essential health benefit provided by an out-of-network provider at an in-network setting towards the enrollee's annual limitation on cost sharing, even if the QHP does not otherwise include an out-of-network benefit; and"
- Revise (f)(2) to read: "(2) Provide a written notice to the enrollee at least ten business days before the provision of the benefit that additional costs may be incurred for an essential health benefit provided by an out-of-network provider in an in-network setting, and including a good faith estimate of the projected amounts for which the covered person may be responsible, up to the enrollee's annual limitation on cost sharing, and a list of in-network providers at the facility where care is being authorized."
- Add a provision protecting consumers from balance billed amounts provided in an emergency in an out-of-network setting.

Relative Network Coverage

We are enthusiastic about HHS's proposal to provide a rating of each QHP's relative network breadth on HealthCare.gov, and we strongly urge HHS to move forward with implementing this system. Currently, consumers have no way of knowing what the relative breadth of their plan's network is. Particularly with the growth of plans with narrow networks and no out-of-network coverage, it is critically important that consumers understand the network that comes with the plan they are choosing and the trade-offs

that come with that choice. Plans with narrow networks may be an appropriate choice for some consumers, but they should know that is what they are buying and that the choice may result in higher out-of-pocket costs later if they need to go out-of-network.

We strongly support HHS developing standard definitions for measuring the breadth of provider networks, along with a clear, concise rating system for communicating the breadth of the networks to consumers. Such a system will enable consumers to make better, more accurate comparisons of the QHPs available to them.

There have been a number of studies, most notably by the McKinsey Center for U.S. Health System Reform and the Leonard Davis Institute of Health Economics (LDI), that have developed metrics for measuring and classifying provider networks based on their relative breadth.[8] In particular, we found the nomenclature used in the LDI study, which classified networks as "extra small," "small," "medium," "large," or "extra large," to be particularly useful and easy for consumers to understand. However, as for all consumer-facing tools, we urge HHS to conduct consumer testing and consult with consumer organizations to inform how best to display this information for the public.

With respect to the methodology, we encourage HHS to factor in both physicians (primary care and specialty physicians) and facilities when evaluating and rating health plan networks. We believe it would be useful to provide separate ratings for breadth of network by categories of providers: primary care professionals, specialty physicians, hospitals, pharmacies, and other facilities. Those ratings could then be rolled up into a single overall rating of network breadth. In this way, networks with a large number of physicians but few hospitals or with a large number of primary care professionals but few specialty physicians could be more accurately analyzed and categorized. Such a system would also allow consumers to obtain rating information on different aspects of care.

Other Issues

HHS solicits comments on whether issuers should be required to survey providers on a regular basis to determine if they are accepting new patients. We are pleased that HHS is acknowledging that this is an important concern that needs to be addressed. Studies in numerous states have documented the high rate of errors found in many provider directories, including with respect to whether listed providers are seeing new patients. For example, a survey in Colorado found that the average accuracy of provider directories sampled was 36.6 percent when it came to providers who were actually available to new patients.[9]

Not only can inaccurate provider directory information result in harmful financial consequences for patients but it can also give regulators an inaccurate picture of a network's capacity to serve the covered population. We therefore support HHS's

---

[8] For example, McKinsey Center for U.S. Health System Reform, "Hospital Networks: Updated National View of Configurations on the Exchanges," June 1, 2014, available at: http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges. And Weiner J and Polsky D. "The Skinny on Narrow Networks in Health Insurance Marketplace Plans." Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation. June 2015, available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027.

[9] Colorado Consumer Health Initiative. "Blog: Hello, is this Dr. X's Office?" October 2015. Available online at: http://cohealthinitiative.org/blog/2015-10-14/hello-dr-x%E2%80%99s-office.

proposal to require issuers to survey providers on a regular basis. In addition to asking whether providers are accepting new patients, issuers should also use this survey to assess whether providers still intend to be in-network and to verify other directory information, such as office location, contact information, and medical group and facility affiliations. Issuers should also be required to contact providers that have not submitted claims within 6 or 12 months, to verify if they still intend to be in-network. Providers that don't respond within a set time period should be removed from directories, as New Jersey requires.

In addition, HHS requests comments on the transparency of issuers' criteria for selecting and tiering providers and whether issuers should be required to make their selecting and tiering criteria available for review and approval by HHS and the state. Although some insurers are using terms like "high value," or "high performing" to describe their networks, there is very little information publicly available about the criteria they use to select or tier providers. However, it often appears that inclusion of providers is being based largely on price, not on the quality of care provided. Moreover, insurers do not use uniform or standardized cost or quality criteria to select or tier providers, and this lack of consistency is confusing both to patients and to providers.

We support requiring issuers to make their criteria for selecting and tiering of providers available both to regulators and to the public. The NAIC's Model Act requires insurers to include a description of the criteria they use to build their network and tier providers in their provider directories and in their access plans. However, we are concerned that these descriptions may be very general and won't provide enough specificity about the quality or other metrics used to be meaningful to regulators or consumers. We therefore urge HHS to require that the specific metrics or factors used to select and tier providers be made available for approval by regulators and to the public.

HHS also asks for comments about other network adequacy standards that should be applied to QHPs in future years, including standards included in the NAIC's Model Act. There are a number of additional standards that were included in the NAIC's Model Act that we urge HHS to adopt for QHPs, as follows:

- Require insurers to have a process in place to enable consumers to access benefits from a non-participating provider at in-network cost-sharing levels when the carrier's network does not include a provider with the professional training and expertise to provide the needed care or a participating provider is not available within a reasonable timeframe or travel distance. Although this process is intended to be used only rarely and not as a substitute for network adequacy, having such a process in place can ensure that patients with rare or extremely complex medical conditions – such as children or adults with a complicated congenital heart defect -- can access an appropriate provider; and
- Require issuers to notify the exchange of any material change to a QHP's network within 15 business days. Medicare Advantage issuers are required to notify CMS of mid-year changes in their networks 90 days in advance and they are also required to notify enrollees of network changes for the following plan year. Material changes to a network should trigger another review to determine whether it is still sufficient, and issuers should be required to bring their networks into compliance as soon as possible.

§156.1256 – Other Notices

We support HHS's proposal to add a new requirement for issuers to, when directed by the FFE, notify their enrollees within 30 days after a plan or benefit display error is identified and inform them of their eligibility for a special enrollment period. We urge HHS to provide additional guidance about what constitutes a plan or benefit display error. For example, we believe that provider directory or formulary errors should warrant notification of enrollees. Enrollees who make plan choices based on the inclusion of their specific providers in the network or their medications on the plan formulary may face significantly increased out-of-pocket costs if it turns out later that this information was erroneous. In those types of situations, we believe consumers should have access to a SEP to switch to a plan that better fits their needs.

Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

Finally, HHS invites comment on whether the treatment of a health insurance issuer's investments in fraud prevention activities should be modified for MLR reporting purposes. As you know, the ACA charged the NAIC with developing the MLR methodology, and the AHA/ASA, through its NAIC Consumer Representative, was very involved in the NAIC's MLR deliberations in 2010. The NAIC extensively discussed how investments in fraud prevention activities should be counted and ultimately determined that issuers could include the cost of fraud recovery activities up to the amount of fraudulent claims recovered as a quality improvement expense. This treatment of fraud expenses was incorporated into HHS's interim final regulation implementing the MLR requirements.

We believe this treatment of fraud prevention expenses appropriately incentivizes issuers to invest in these efforts, and we strongly oppose changes to the MLR regulation that would permit issuers to count additional fraud spending as anything other than an administrative expense. That is, fraud prevention should not be considered a claims expense or a quality improvement activity (QIA). Any such change would adversely impact patients and consumers by undermining the fundamental goal of the MLR requirement of "helping consumers realize the full value of their health insurance payments."

The NAIC has created a MLR Quality Improvement Activities Subgroup with the charge to: "Review new quality improvement (QI) initiatives, as reported annually on the Supplemental Health Care Exhibit Allocation Report and make recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) on certifying for inclusion or exclusion in the QI expense category of the Supplemental Health Care Exhibit." This Subgroup held a hearing on November 20 during which they heard testimony from a range of interested stakeholders. During this hearing, regulators reacted skeptically to industry testimony that urged the NAIC to count fraud prevention as a QIA, and regulators requested that industry provide more specific examples and justification for why a change in the current treatment is necessary by January 15, 2016.[10]

[10] Hansard, Sara. "State Regulators Wary of Insurer Requests on Medical Loss Ratio." *BNA Health Care Daily Report*, Nov. 23, 2015. Available online at: http://www.bna.com/state-regulators-wary-n57982063849/.

Like the regulators, we heard no compelling reasons why changes to the treatment of fraud prevention expenses are warranted. However, if changes are to be made to how fraud expenses are counted, those changes should be made only if the NAIC makes that recommendation to HHS, as directed by the ACA, after its MLR QIA Subgroup has completed its deliberations on whether new QI expenses should be included.

*****

Thank you again for the opportunity to share our comments on these issues related to prescription drug benefits, network adequacy, the MLR, and other important topics. If you have any questions, please feel free to contact Stephanie Mohl, Senior Government Relations Advisor, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

Mark A. Creager, MD, FAHA
President