

**Progress, Challenges and Opportunities: *Taking the Next Steps to Reduce Barriers to Access and Reform Medicare Physician Payments***

**Annual Report on the State of the Nation's Health Care  
From the  
American College of Physicians**

**February 11, 2014**

**Introduction**

2014 is a critical year for health care in the United States. *Because of the Affordable Care Act, for the first time in American history, no American has to worry that health insurance coverage will be denied, taken away or over-charged to them because they have a pre-existing condition. Because of the ACA, no American has to worry that their benefits in a given year or over a lifetime will be capped, putting them at risk of bankruptcy. Because of the ACA, being a woman no longer is considered to be a pre-existing condition. Because of the ACA, every American, including seniors on Medicare, will have guaranteed access to life-saving preventive services at no cost to them.*

Yet as would be expected from any major change, challenges will arise as health reform gets fully implemented. Such was the case with the Medicare Part D program when it was implemented in 2006, and such is the case now. The answer to overcoming such challenges is to work in a constructive way to diagnose and fix them, not to turn our backs on the critical health reforms stemming from the ACA.

Two health reform-related challenges in particular merit attention.

One is the growing numbers of health plans that are limiting patient choice of physicians and hospitals through narrow provider networks. The trend toward ever-narrower networks pre-dates the ACA itself, and can be found in many Medicare Advantage plans and private health insurance plans

offered by large employers. Many plans also are imposing overly restrictive medication formularies that may make it difficult for patients to afford the prescriptions that work best for them. The College believes that the federal government has a special responsibility to ensure that federally-qualified health plans (QHPs), whether offered through the exchanges created by the ACA, or through Medicare Advantage, do not create undue barriers to patients getting appropriate care from physicians they trust and the medications they need.

Another challenge is that many of the poorest Americans who were expected to benefit from the ACA are being left out in 2014 because their states have declined to accept federal dollars to expand Medicaid to everyone with an income up to 133 percent of the federal poverty level. This is not a problem with the ACA itself, but with the states that have turned their backs on their poorest residents. Related, a key program to improve Medicaid enrollees' access to primary care physicians and medical specialists, called the Medicaid pay parity program, is set to expire at the end of 2014. This program needs to be reauthorized by Congress and extended.

***2014 also holds the promise of being the year when Congress finally enacts comprehensive Medicare physician payment reform that includes repeal of the Medicare Sustainable Growth Rate (SGR) formula.*** House and Senate committees with jurisdiction over Medicare have advanced bipartisan legislation to repeal the SGR and accelerate the transition to value-based payment and delivery models. The budget cost of SGR repeal continues to drop. ACP and other physician membership organizations have provided substantial input on the bills and are working diligently to prepare our members for change. Yet Congress must take the next step and get SGR repeal and physician payment reform enacted into law, before the next round of SGR-scheduled cuts takes place on April 1.

In today's report, the American College of Physicians offers its assessment of where things stand with both the Affordable Care Act and Medicare Physician Payment Reform and the next steps to be taken to build on the progress made:

- **We report on specific recommendations we sent today to HHS Secretary Kathleen Sebelius, the National Association of Insurance Commissioners, America's Health Insurance Plans, and the Blue Cross and Blue Shield Association of America, proposing improvements to address concerns about the impact of unduly narrow networks and restrictive drug formularies and related issues on patient choice, access and continuity of care.** We call for a balanced, constructive and transparent approach to allow patients/consumers to make informed choices, to reduce unnecessary interruptions in continuity of care, and to ensure fairness and due process to clinicians and patients, including improvements in federal and state regulatory oversight of QHPs.
- **We renew our call on all states to do the right thing for their poorest residents by accepting federal dollars to expand the program to all persons with incomes up to 133 percent of the federal poverty level, and we ask Congress to reauthorize and extend a program to increase Medicaid access to primary care.**
- **We again urge the House and Senate leadership to take immediate action to advance comprehensive Medicare physician payment reform across the finish line, including our recommendations on key policies to support physicians' transition to value-based payment and delivery models.**

### **Where do things stand with the Affordable Care Act?**

#### ***Enrollment By the Numbers***

Despite the troubles with the initial roll-out of the ACA, and particularly, the federal enrollment portal, [www.healthcare.gov](http://www.healthcare.gov), the consumer experience with

enrollment in the federally-administered marketplace plans appears now to be going relatively smoothly. We recognize though that further improvements are needed and ongoing, and it is especially urgent that people be able to appeal incorrect eligibility determinations online and report changes in their circumstances that affect coverage, like having a child. Many states that are running their own exchanges, like California and Kentucky, are reporting robust and consumer-friendly enrollment trends, although some states, like Oregon and Maryland, continue to report significant problems with web-based enrollments. And notwithstanding the large number of states that have not yet agreed to expand Medicaid, enrollment in Medicaid has exceeded expectations. Combined, up to 12 million Americans have signed up or been deemed eligible for ACA coverage through the exchanges, Medicaid, or young adults on their parents plans as of January 31, 2014.<sup>i,ii,iii</sup>

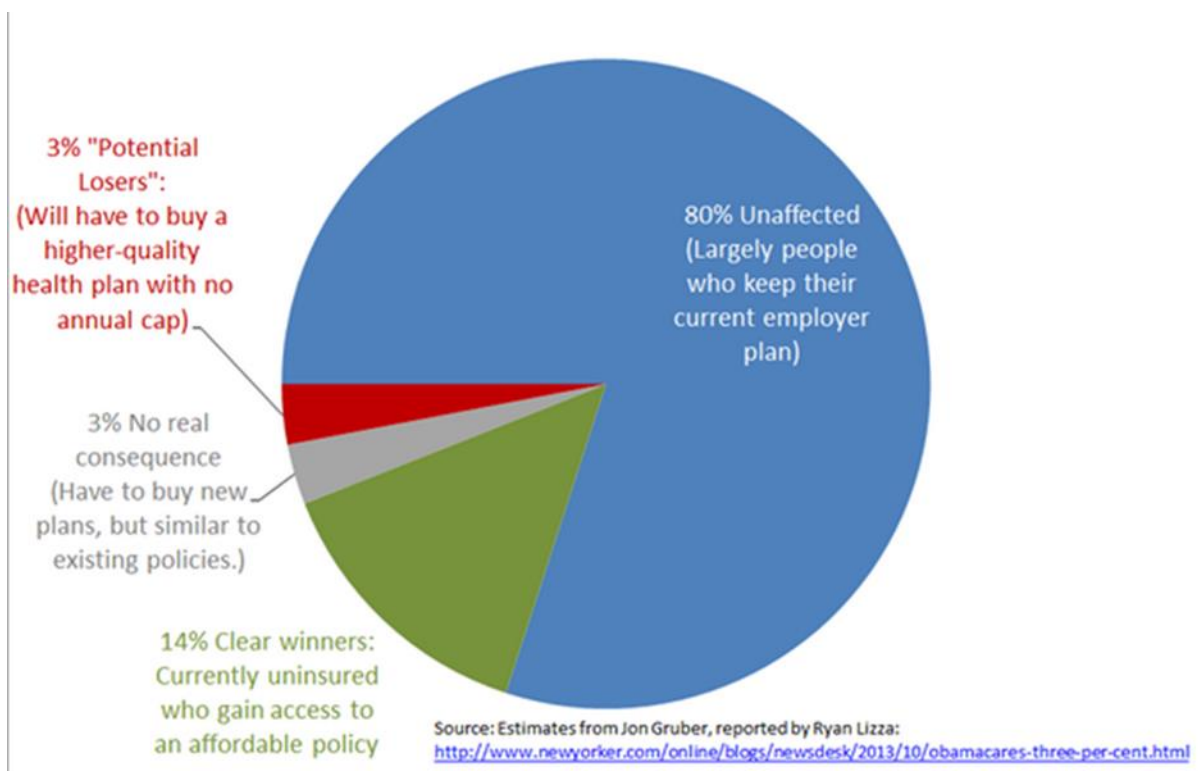
These enrollment trends confirm that “if you build it, they will come” by the millions when it comes to people enrolling in the affordable health insurance options being built by the ACA. It is too soon to determine if the enrollment mix of young and old, healthy and unhealthy, will achieve the right balance to ensure stable premiums during the next open enrollment period for 2015, although a new study suggests that even if enrollment of younger and healthier persons initially falls short of projections, a “death cycle” in insurance premiums is unlikely.<sup>iv</sup> Also, the experience in Massachusetts, which had a similar open enrollment period, suggests that younger people tend to sign up later in the enrollment process and closer to the deadline for open enrollment. The College supports existing ACA provisions to temporarily stabilize the insurance market should adverse selection problems occur.

ACP recognizes that a relatively small percentage of the population received notices that they had to replace their individual health insurance with policies that meet the ACA’s benefits and modified community rating requirements, and in an even smaller percentage of cases, they reported that the QHPs available to them through the exchanges had higher premiums and higher cost-sharing than they had under their previous individual insurance plans. This appears to particularly be the case for people who earn near or above the maximum income eligibility threshold (400 percent of the Federal Poverty Level (FPL)) to obtain tax credit subsidies to buy coverage through the exchanges, and in certain geographic regions with less

competitive insurance markets. The College sympathizes with any person who has had to replace their current coverage with a more expensive plan, even though the plans they are now buying have ACA protections and benefits that were not guaranteed by their previous plans, including prohibiting plans from charging more, and denying or cancelling coverage for people with pre-existing conditions.

Yet a closer look at the numbers shows that the vast majority of Americans will be better off under the ACA. The highly respected Brookings Institution recently published a pie chart on the ACA's impact.<sup>v</sup>

### Impact of the Affordable Care Act: *By the Numbers*



As shown in the chart:

- 80 percent of Americans are mostly unaffected by the ACA's benefit requirements because they get to keep coverage from a large employer that already meets the law's standards. (Although they will benefit from ACA's requirement that parents' health plans cover young adults, from its prohibition on annual and lifetime limits on coverage, from the requirement that health plans spend at least 85 percent of the premium dollar on direct patient care instead of administration, and from no-cost coverage of preventive services.);
- 14 percent will clearly be better off because they are the currently uninsured and will gain access to an affordable policy;
- 3 percent will have no real consequence because they will have to buy new plans that are "similar to existing policies," and
- Only 3 percent are "potential losers" because they will "have to buy a higher quality health plan with no annual cap."

More specifically, people who will directly benefit from the ACA include:

- Uninsured persons with serious health problems. "About 1.8 million uninsured people have received a previous cancer diagnosis. More than 2.8 million have been diagnosed with diabetes. Altogether, more than 5.7 million have been diagnosed with these ailments, or stroke, emphysema, heart failure, and similarly serious conditions," reported health policy scholar Harold Pollack in a recent blog post.<sup>vi</sup>
- 13 million low-income uninsured Americans who will get covered under Medicaid/CHIP, according to a May 2013 Congressional Budget Office estimate, online.<sup>vii</sup> In most states Medicaid enrollment so far is outpacing signups for private health insurance offered through the ACA's marketplaces.

- Women, because they no longer can be charged higher premiums simply because of their gender and because maternity benefits are now included in all ACA-QHPs.
- Older people who are not yet eligible for Medicare, because the ACA limits how much premiums can vary by age.

We recognize that there are some who may conclude that they are not yet benefiting from the ACA including:

- A small subset of the people who buy insurance from the individual market. Although fewer than 6 percent of Americans buy their insurance through the individual market in any given year<sup>viii</sup>, most of them must soon purchase a replacement plan that meets federal standards, and for some, the replacement plan will cost more. After a public outcry over the insurance cancellations in this market, the Obama administration has proposed that people be allowed to keep their individual insurance for another year. But this temporary administrative “fix” requires approval of state insurance commissioners, and not all are going along. Many of the people who have to replace their policies, though, will find that they can get a less expensive plan through the state insurance marketplaces, and most of them will get federal subsidies to help pay the premium. Families USA, a consumer advocacy group, calculates that “71 percent of people in the individual market under age 65 have incomes at or below 400 percent of poverty,” making them eligible for the ACA’s premium subsidies.<sup>ix</sup>
- Some younger and healthier people who are not insured by a large employer. A portion of this group may pay more to buy a plan on the marketplace so that older and sicker people pay less. But 9 out of 10 of them will qualify for ACA’s premium subsidies. Also, according to [Media Matters](#), another five million younger persons have incomes that will make them eligible for Medicaid if their state is participating in the ACA’s Medicaid expansion.<sup>x</sup> And young people up to age 26 can stay on their parents’ insurance plans.

- Some men, because the ACA prohibits insurers from varying premiums by gender. Men and women now will pay the same premium for the same coverage, meaning that some men will pay more.

When all is said and done, the College firmly believes that every American ultimately benefits from a law that ensures access to health insurance that cannot be denied, taken away or over-charged when we get sick, that guarantees access to evidence-based benefits including prevention, that prohibits annual and lifetime limits on benefits, and that provides premium assistance to help people buy coverage, and access to Medicaid for the poor and near-poor (in states that have agreed to Medicaid expansion).

### ***Health Plan Barriers to Continuity of Care***

The promise of providing all Americans with access to affordable health insurance is undermined when health plans impose unnecessary or excessive restrictions on patients' ability to continue to see the physicians they trust or receive the medications they need. The federal government, the insurance industry and state regulators have a responsibility to address such barriers, not only in qualified plans offered through the ACA's exchanges, but also in the Medicare Advantage program and health plans offered by employers.

Access is more than having health insurance. It is also about having the ability to see a physician you trust, to be able to get care from the hospital or cancer center that is close to home and/or has the facilities and reputation you need, to get the prescriptions that are most effective for your medical condition, and to avoid paying so much out of pocket that you cannot afford it. Yet, concern is growing that the coverage options being offered to consumers increasingly try to control costs by limiting access to clinicians and medications.

The cost-control limitations on access can come in several forms. One is for the insurer to directly limit patient choice of physicians and hospitals by establishing "narrow networks." Another is for the insurer to limit access to expensive drugs that a physician prescribes for a patient by establishing restrictive formularies. There is an urgent need for constructive and balanced policies, with appropriate regulatory oversight, to ensure that such restrictions do not impose unnecessary



requirements on patients getting care from a physician they trust or the medications they need.

The College does not advocate that health plans must provide unfettered access to every physician, hospital or medication. We do not seek “any willing provider” laws, which would require health insurers to include in their network any clinician who wants to be in the plan’s network, no matter the quality and cost of care associated with the clinician or whether the demand for health care services is sufficient to justify adding more clinicians to the plan’s network. We recognize that some physicians and hospitals have unjustifiably high utilization rates, poorer outcomes, and high admission and readmission rates. We do not advocate that every medication be on a plan’s formulary when there is an equally effective and less expensive alternative.

**In letters sent today to Secretary Kathleen Sebelius, the National Association of Insurance Commissioners, America’s Health Insurance Plans, and the Blue Cross and Blue Shield Association (included in this report’s appendix), ACP instead calls for balance, transparency, fairness and facilitation of real informed choice as it relates to a health plan’s network adequacy, medication formularies, and related issues that directly affect access and continuity of care.**

The College is pleased that on February 4, the Centers for Medicare and Medicaid Services released a letter to insurers in the federally-facilitated marketplace that would enhance strengthen network adequacy requirements, increase the supply of essential community providers, and provide greater transparency and scrutiny of prescription drug formularies.<sup>xi</sup> Building upon this letter and previous agency directives, ACP proposes improvements to the existing standards and rules governing QHPs to:

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

***Network Adequacy Standards:*** A number of reports indicate that many QHPs are offering narrow networks, sharply restricting the number of physicians and hospitals from which patients can receive care. If organized correctly, health plan networks can be used to better coordinate care and encourage use of high-quality physicians. However, over-strict networks endanger continuity of care and fracture the physician-patient bond. The ACA establishes a federal standard for network adequacy and states may establish stricter standards. While these safeguards are important, we are already seeing that narrow networks are posing problems for those seeking marketplace-based insurance:

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

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

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

- **Improve current network adequacy standards by taking into account additional criteria—including patient-to-physician ratios, use of out-of-network clinicians and hospitals, and urban, suburban, and rural area-relevant standards—as indicators of access. These would be in addition to developing time, distance and other standards for QHP networks beginning in 2015, as proposed in CMS’s February 4 letter to insurers.**
- **Develop network adequacy standards for PPOs, including factors such as whether a hospital contracts with an in-network physician.**
- **Continuously monitor network adequacy.** We are encouraged that in an April 2013 letter to insurers, CMS stated that it will be monitoring network adequacy via complaint tracking and random spot checks of QHP network data. **We recommend that such compliance and complaint information be made available to the public.**
- **CMS must work closely with state regulators to address network adequacy concerns that are most relevant to each state (and the individual health plan service areas within each state).** We are encouraged that the February 4 letter extends existing federally-facilitated marketplace network adequacy standards through increased monitoring of the access provided to primary care physicians, hospital systems, mental health clinicians and facilities, and oncology care.
- **The College also supports the enhanced requirements for the inclusion of essential community providers (ECP) such as federally qualified health centers, Ryan White HIV/AIDS providers and safety net hospitals; however, the 30 percent ECP threshold should be a minimum, and QHPs should be encouraged to incorporate additional ECPs to meet the needs of patients in the service area. CMS should closely scrutinize QHP requests for exceptions to this rule and closely monitor plans that are granted exceptions, requiring changes as needed. Contingency plans must prioritize continuity of care with the patient’s preferred health care clinician.**

*Network Development and Transparency:* ACP supports efforts to consider value in the development of health plan networks, as long as the process is balanced,

transparent, fair, and provides real choice. **The process through which networks are developed and the factors considered by insurers should be made public; CMS and state regulators should require further safeguards to ensure access and continuity of care:**

- **Mandate that QHPs provide physicians and their patients advance notice of network changes and the opportunity to appeal.**
  - **Physicians should be provided with detailed reasons as to why their contract was terminated.**
  - **They should be able to comment on and challenge alterations as necessary.**
  - **All network selection and de-selection decisions should be on record.**
  - **Health plans or networks should provide public notice within their geographic service areas when physician applications for participation are being accepted.**
- **Ensure that physicians have the option of applying to any health care plan or network in which they desire to participate and to have their application judged based on objective criteria that are available to both applicants and enrollees.**
- **Require transparency in the criteria used by QHPs to determine who will be allowed into networks. Performance measures and methodologies used for network selection and tiering should conform to the following standards:**
  - **Measures should be meaningful to consumers and reflect the importance of patient-centered care.**
  - **Physicians and physician organizations should have input to these programs and the methods used to stratify performance. They should also have access to the information collected and should be given notice before individual information is released.**
  - **Measures and methodology should be transparent, valid, accessible, and understandable by consumers, physicians, and other clinicians.**
  - **Measures should be based on national standards, primarily standards endorsed by the National Quality Forum (NQF).**

**Standards from other groups and organization may be used, but they should be replaced by NQF standards once available.**

- **QHPs should consider multiple criteria related to professional competency, quality of care, and the appropriate utilization of resources. In general, no single criterion—including cost--should provide the sole basis for selecting or excluding a physician from a plan's network.**
- **In keeping with nondiscrimination guidelines, QHPs should be prohibited from excluding health care clinicians because their practices contain substantial numbers of patients with expensive medical conditions.**

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

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

- **Require QHPs to provide up-to-date network directories in real-time when a potential enrollee is choosing a plan, including making prompt updates upon receipt of new information relating to network participation.**
  - **Create an online search tool to allow users to search by clinician and hospital name and filter out health plans that do not include the consumer's chosen clinician or hospital in network. ACP is**

very pleased that the February 4 letter indicates that the agency is considering collecting the necessary data to create such a search tool. Marketplace websites should also make available a formulary search tool, enabling consumers to search for plans based on whether their medications are covered in the plan's formulary.

- **Create an additional enrollment period to allow patients to choose another QHP if an outdated network directory has incorrectly listed an enrollee's preferred physician as being part of the network.** ACP appreciates the December 17, 2013 interim final rule urging (but not requiring) QHPs to provide the most current online directory to marketplace-plan shoppers and treat out-of-network physicians as in-network if they were listed in the QHP's in-network provider directory at the time of the patient's enrollment. **If this cannot be accomplished, CMS should require an additional enrollment period allowing patients to choose another health plan.** This may be permitted in 45 CFR 155.420(d)(5), which states that a special enrollment period may be triggered if "(a)n enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee."
- **Require QHPs to establish "health care provider hotlines" to connect physicians, hospitals and other providers to QHP representatives to answer questions, verify patient enrollment, and obtain other information.** Better access to information is crucial, especially as patients transfer between plans and/or health insurance programs and experience changes in advance premium tax credit and cost-sharing assistance eligibility. QHPs should facilitate physicians' verification of enrollment and health plan information through an online portal and **must inform physicians that they are included in-network.** This will ensure that clinicians can maintain a patient panel that will guarantee access for existing patients and help clinicians accurately determine whether they can absorb additional patients covered by marketplace-based plans.

***90-day grace period prior to termination of coverage for non-payment of premiums:*** The October 3, 2013 Federally-Facilitated Marketplace Enrollment Operational Policy & Guidance Manual states that QHPs must notify providers of

the possibility of denied claims for services incurred during months two and three of the grace period for enrollees receiving advance premium tax credits and that CMS expects issues would provide such notice within the first month of the grace period and throughout months two and three. **This should be improved:**

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

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

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

**access for physician-to-physician dialogue with the ability to resolve any clinical or medical-necessity issues.**

***Improve the prescription drug formulary exception process:*** ACP appreciates that the February 4 letter strongly recommends that QHPs facilitate continuity of care by providing off-formulary drugs to enrollees during the first months of enrollment without going through the exceptions process. **This temporary transitional policy may help for certain acute care episodes, but additional safeguards should be established:**

- **QHPs with restrictive formularies should allow patients to continue to receive disputed medications during an entire exception review process, and if an exception is granted, continue to provide coverage for the exception drug during subsequent plan years. There must be a mechanism for expedited internal and external review and appeals in urgent health situations. Federal and state regulators should mandate that insurers and independent review entities provide a decision to the patient and provider/prescriber within 24 hours for urgent health situations or 72 hours for non-urgent situations. CMS should evaluate the prescription drug exception and the claims denial appeals processes as well as appeal approval/denial rates as QHP certification and recertification criteria.**
- **Federal and state regulators and other stakeholders must closely monitor formularies and other benefit design features to ensure that coverage does not exclude patients with complex chronic conditions, including patients with cancer, transplants, mental health treatment, HIV/AIDS, and hepatitis C. Such limited formularies and plan restrictions would violate the spirit of the ACA's nondiscrimination provisions which prohibit discrimination based on factors including health status, disability, age, race, gender and sexual orientation. A July 2013 report issued by the Georgetown University Health Policy Institute identified troubling concerns from stakeholders – including state regulators and consumer advocacy groups – about discriminatory benefit designs and highlighting the potential for discrimination in the design of limited networks and drug formularies. Among the recommendations, stakeholders**



stressed the need for robust, continuous monitoring of potentially discriminatory benefit designs<sup>xvi</sup>.

- **The College is encouraged that the February 4 letter notes that CMS will provide increased scrutiny of essential health benefit packages to prevent plans from discriminating against vulnerable, complex-needs patients.**
- **The College supports requiring QHPs to attest that benefit packages are not discriminatory.**
- **We support CMS's intent to monitor complaints and analyze appeals. The College especially welcomes enhanced oversight of plans that require prior authorizations and/or step therapy requirements in a particular drug category or class.**
- **We also request that CMS consider offering alternatives to arbitrary prior authorization requirements such as creating incentives for the application of appropriate use criteria, and excusing medical practices that are participating in value-based payment programs from prior authorization requirements.**
- **QHPs that violate anti-discriminatory benefit design rules should be stripped of certification.**

### *Ensuring Access to Medicaid*

The people who are most at risk of being left out of coverage under health reform are the 5 million low-income people<sup>xvii</sup> who were supposed to get Medicaid coverage under the ACA, but currently cannot qualify because they live in a state that is not expanding Medicaid. This is a fault not of the ACA itself but of the states that have chosen not to accept federal funding to cover this group as originally intended by the ACA. The result is that three out of five of the poorest Americans, all residing in states that have declined to expand Medicaid, will initially go without coverage because their incomes fall below the federal poverty line and under the ACA, they are ineligible to get tax credit subsidies to buy private insurance.

The encouraging news is that a majority of states have expanded Medicaid or expressed the intent to do so<sup>xviii</sup>, with the Republican governor of Utah being among the latest. Leaving Utah's poorest residents without health insurance "is not

fair and it is not right” Governor Herbert said in his January 29, 2014 “State of the State” speech to Utah lawmakers. “Assisting the poor in our state is a moral obligation that must be addressed.”<sup>xi</sup> He is right, and ACP is committed to doing everything it can to encourage the remaining states to meet their moral obligation to cover their poorest residents.

In October 2013, ACP urged all of its chapters to encourage their states to expand Medicaid. Despite a very difficult political environment in some states, our chapters came through for their patients. Armed with state-specific data we provided them, they told their states that expanding Medicaid is the right thing to do, for the health of their populations, and also, the right thing to do for the health of their state budgets.

The College is now in the process of updating the information we provided to our chapters, to help those in states that have not yet agreed to the expansion, to again make the case that:

- Opening up Medicaid to every American with incomes up to 133 percent of the FPL is the fiscally smart thing for states to do. Even though the federal contribution declines gradually over the next ten years, at no time will it pay less than 90 percent of the cost, and when other savings to the states are considered, many state budgets will end up better off than if they don’t expand Medicaid.<sup>xx,xxi</sup> States that wait another year or more will be leaving federal dollars at the door that otherwise would go to the benefit of their residents, and their treasuries.
- It is wrong to leave the poorest of the poorest of the poor without coverage. Without access to Medicaid, people with incomes below the poverty level will have no access to subsidized coverage under the ACA, while higher income residents will get subsidies to buy coverage through the exchanges.
- Medicaid coverage also is associated with better self-reported health and preventive service use, and people enrolled in Medicaid are less likely to report that costs are creating a barrier to getting the care they need.<sup>xxii,xxiii</sup>

**Today, ACP makes the following recommendations:**

- **All states should authorize expansion of Medicaid to persons with incomes up to 133 percent of the FPL, by no later than the end of this year. CMS should work with the states to consider options and grant waivers to states to expand Medicaid in a manner that best meets the state's needs, provided enrollees are not subjected to fewer benefits or higher cost-sharing or eligibility requirements than is required under the federal government's current Medicaid standards.**
- **Congress must do its part to ensure that Medicaid enrollees will have access to a personal physician by reauthorizing a program to raise Medicaid payment rates for primary care to no less than the applicable Medicare rates and extending the program to include those ob-gyn physicians who meet the 60 percent primary care services threshold currently in place. This program, which is scheduled to sunset at the end of 2014, is essential to ensuring access primary care, both in states that have agreed to the Medicaid expansion as well as those that have not.**

### **Where do things stand on Medicare Physician Payment Reform?**

Congress has never been closer than it is today to enacting comprehensive, bipartisan legislation to repeal the SGR formula and reform physician payments. The "Medicare Beneficiary Access Improvement Act of 2013," which would repeal Medicare's Sustainable Growth Rate (SGR) and accelerate the transition to value-based payment models, was reported out of the House Ways and Means Committee and Senate Finance Committees in December, 2013. A similar bill was reported out of the House Energy and Commerce Committee in July, 2013. On February 6, agreement was reached among the chairs and ranking members of all three of these committees on legislation, the "SGR Repeal and Medicare Provider Payment Modernization Act of 2014" (H.R. 4015). In addition, the Congressional Budget Office has reduced by more than half the estimated cost of repealing the SGR and replacing it with a new value-based payment program. For instance, the House of Representatives version of the "SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013" (H.R. 2810), which includes positive updates for physicians, was estimated to cost \$121 billion over 10 years.<sup>xxiv</sup>

The College strongly supports agreement reached by the three committees. ACP is especially pleased that the agreement includes the following elements:

- Repeals the SGR and replaces it with a system focused on quality, value, and accountability.
- Removes the imminent threat of physician payment cuts and ensures a 5-year period of annual updates of 0.5 percent to transition to the new system.
- Improves the existing fee-for-service system by rewarding value over volume.
- Consolidates the three existing quality programs into a streamlined and improved program that rewards physicians who meet performance thresholds and improve care for seniors.
- Rewards physicians that engage in clinical practice improvement activities that will help facilitate their future participation in alternative payment models (APMs).
- Implements a process to improve payment accuracy.
- Creates incentives for care coordination efforts for patients with chronic care needs.
- Creates incentives for physicians to move into APMs, including a 5 percent bonus to physicians who receive a significant portion of their revenue from an APM, including patient centered medical homes (PCMH).
- Establishes a process to review and recommend physician-developed APMs based on criteria developed through an open comment process.
- Expands the use of Medicare data for transparency and quality improvement.

**ACP strongly recommends that Congress pass legislation that incorporates the policies in this bipartisan, bicameral framework no later than March 31, 2014, in time to prevent a scheduled 24 percent SGR payment cut on April 1, 2014. The College strongly opposes another temporary patch or freeze: with agreement having been reached on a bipartisan, bicameral bill to reform Medicare physician payments and repeal the SGR, there is no reason for Congress to put off acting now to send real reform to the President for his signature.**

## **Conclusion**

This year, the state of the nation's health care is unlike it has ever been before. For the first time, Americans are beginning to benefit from health reforms to ensure that everyone will have access to affordable coverage that includes essential benefits. For the first time since Congress enacted the highly flawed Medicare SGR formula in 1997, and some 12 years since the SGR caused the first scheduled cut in physician payments in 2002, Congress is on the verge of passing bipartisan, bicameral legislation to repeal the SGR and accelerate the transition to value-based payment and delivery models.

Let's build upon the enormous progress that already has been made, so that 2014 truly is viewed as a year when the state of the nation's health care turned a corner in its journey to expand access for all Americans and bring greater value to Medicare physician payments.

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<sup>i</sup> HHS Office of the Assistant Secretary for Planning and Evaluation. Health Insurance Marketplace: January Enrollment Report. January 13, 2014.

[http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib\\_2014jan\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf)

<sup>ii</sup> CMS. Medicaid & CHIP: December Monthly Applications and Eligibility Determinations Report. January 22, 2014.

<http://www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/December-2013-Enrollment-Report.pdf>

<sup>iii</sup> Factcheck.org. Facts of the Union. January 29, 2014. Accessed at <http://www.factcheck.org/2014/01/facts-of-the-union/>

<sup>iv</sup> Leavitt L, Claxton G, and Damico A. The Numbers Behind the "Young Invincibles" and the Affordable Care Act.

Kaiser Family foundation. December 17, 2013. [http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-](http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/?_hstc=87270983.cf85ffd717458677bc44c92ba702ea57.1391439805878.1391439805878.1391442148264.2&_hssc=87270983.2.1391442148264&_hsfp=1679700330)

[act/?\\_hstc=87270983.cf85ffd717458677bc44c92ba702ea57.1391439805878.1391439805878.1391442148264.2&\\_hssc=87270983.2.1391442148264&\\_hsfp=1679700330](http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/?_hstc=87270983.cf85ffd717458677bc44c92ba702ea57.1391439805878.1391439805878.1391442148264.2&_hssc=87270983.2.1391442148264&_hsfp=1679700330)

<sup>v</sup> Brookings. "Chart: Winners and Losers from Obamacare". November 5, 2013. Accessed at:

<http://www.brookings.edu/blogs/brookings-now/posts/2013/11/chart-winners-and-losers-from-obamacare>

<sup>vi</sup> Pollack, Harold. "ACA's winners far outnumber its losers." November 20, 2013.

[www.healthinsurance.org/blog/2013/11/20/acas-winners-far-outnumber-its-losers/](http://www.healthinsurance.org/blog/2013/11/20/acas-winners-far-outnumber-its-losers/)

<sup>vii</sup> Congressional Budget Office. CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage. May 2013. Accessed at

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[http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190\\_EffectsAffordableCareActHealthInsuranceCoverage\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf) on February 3, 2014.

<sup>viii</sup> Families USA. How Does the Affordable Care Act Affect People Who Buy Health Insurance in the Individual Marketplace? December 20, 2013. Accessed at <http://www.familiesusa.org/ACA-individual-market/>.

<sup>ix</sup> [www.familiesusa.org/ACA-individual-market/](http://www.familiesusa.org/ACA-individual-market/)

<sup>x</sup> Media Matters. Top 4 Obamacare Myths About Millennials Dispelled. November 2013. Accessed at <http://mediamatters.org/research/2013/11/21/top-4-obamacare-myths-about-millennials-dispell/197008>.

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

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

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

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

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

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

<sup>xvii</sup> Kaiser Family Foundation. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. October 2013. Accessed at <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

<sup>xviii</sup> <http://www.washingtonpost.com/blogs/govbeat/wp/2014/01/24/with-utah-on-board-a-majority-of-states-now-back-medicaid-expansion/>

<sup>xix</sup> <http://www.sltrib.com/sltrib/politics/57467293-90/utah-herbert-address-quality.html.csp?page=1>

<sup>xx</sup> Buettgens M, Dorn S, and Carroll C. Consider Savings as Well as Costs: State Governments Would Spend at Least \$90 Billion Less with the ACA than Without It from 2014 to 2019. Urban Institute. July 2011. Accessed at <http://www.urban.org/UploadedPDF/412361-consider-savings.pdf>

<sup>xxi</sup> Kaiser Family Foundation. The Role of Medicaid in State Economies and the ACA. November 2013. Accessed at <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf>

<sup>xxii</sup> Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP, et al; Oregon Health Study Group. The Oregon experiment—effects of Medicaid on clinical outcomes. *N Engl J Med*. 2013;368:1713-22

<sup>xxiii</sup> Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. *N Engl J Med*. 2012;367:1025-34. [PMID: 22830435]

<sup>xxiv</sup> Congressional Budget Office (CBO) cost estimate for H.R. 2810, SGR Repeal and Medicare Beneficiary Access Act of 2013. January 24, 2014. Accessed at: <http://www.cbo.gov/publication/45040>.

## APPENDIX A



February 11, 2014

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

Dear Secretary Sebelius,

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

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

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

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

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

#### Networks: Robust Standards and Transparency

Having an insurance card is essential to getting health care, but equally important is ready access to physicians of the patient's choice. Health plan networks that force patients to sever their relationship with their longtime physician, or travel great distances to their preferred hospital or cancer-care center, subvert the intent of the Affordable Care Act's effort to expand access to quality health care.

Transparency in the network development process is imperative. The recent situation with UnitedHealthcare's Medicare Advantage plans<sup>2</sup> — where abrupt changes in the plan's network resulted in confusion for patients and physicians — highlights the need to require QHPs and Medicare Advantage plans to disclose network development criteria and to regularly scrutinize networks for adequacy and stability.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

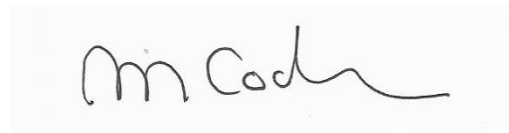
temporary transitional policy may help for certain acute care episodes, but additional safeguards should be established:

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Molly Cooke", on a light blue background.

Molly Cooke, MD FACP  
President  
American College of Physicians

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

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

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

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

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

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

<sup>7</sup> 45 CFR 156.230

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

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

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

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

## APPENDIX B



February 11, 2014

Adam Hamm  
President  
National Association of Insurance Commissioners  
444 North Capitol St., N.W.  
Suite 701  
Washington, D.C. 20001

Dear Mr. Hamm,

The American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine specialists (internists), related subspecialists, and medical students, writes to express our interest in working with the National Association of Insurance Commissioners (NAIC) members and insurance regulators throughout the country to achieve the Affordable Care Act's (ACA) goal of expanding access to affordable, high-quality health insurance. The ACA establishes crucial insurance reforms that for the first time protect our nation's patients from pre-existing condition coverage exemptions, undue insurance plan rescissions, and volatile premiums and cost-sharing, among other important reforms. Patients can now be assured that the coverage they purchase through a health insurance marketplace will provide essential health benefits as well as preventive services without cost sharing.

The NAIC and its state insurance regulator members play an important role in providing oversight of the health insurance industry. With major changes occurring as a result of the ACA, the mission of state insurance regulators to provide consumer education and ongoing monitoring of the new health insurance landscape is even more crucial. ACP writes to offer its assistance to insurance regulators to ensure that the implementation of the ACA's insurance regulations results in a system that is more fair, honest, and protects the rights of patients.

ACP recommends that physicians, insurers and federal and state regulators work together to promote better access to high-quality physicians by enabling patients to consult up-to-date provider directories at the time of plan selection, provide a transparent and cooperative process for provider network development, and maintain ongoing oversight and monitoring of health insurance marketplace plans to determine and rectify potential network access problems. ACP respectfully offers the following recommendations calling for greater transparency and monitoring of provider networks, benefit packages, formularies, and the appeals process to prohibit discriminatory health plan designs that cut off vulnerable patients from necessary care.



Attached is the complete letter sent to Health and Human Services Secretary Kathleen Sebelius, which suggests additional recommendations.

## Recommendations

*Provider Network Adequacy:* ACP supports the minimum network adequacy standards established in federal regulations<sup>i</sup> requiring QHPs to ensure access to essential community providers, and a network sufficient in number and types of clinicians including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. We are encouraged that **CMS states in its February 4 draft letter to issuers in the federally-facilitated marketplace that it proposes to review plan lists of participating physicians and hospitals to determine whether the networks provide sufficient access without unreasonable delay, focusing on access to hospital systems, mental health, oncology, and primary care clinicians. CMS states that it intends to use its review to develop time and distance and other standards for future network review and we request that state regulators work with their federal counterparts to develop this criteria.**

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

- **Improve current network adequacy standards by taking into account additional criteria—including patient-to-physician ratios, use of out-of-network clinicians and hospitals, and urban, suburban, and rural area-relevant standards—as indicators of access.** These would be in addition to developing time, distance and other standards for QHP networks beginning in 2015, as proposed in CMS's February 4 letter to insurers.
- **Regulators should also encourage network adequacy standards for PPOs, including factors such as whether a hospital contracts with an in-network physician.<sup>ii</sup>**
- **Continuously monitor network adequacy.** We are encouraged that in an April 2013 letter to insurers, CMS stated that it will be monitoring network adequacy via complaint tracking and random spot checks of QHP network data.<sup>iii</sup> We recommend that such compliance and complaint information be made available to the public. We urge state and federal regulators to closely monitor network adequacy and take action to correct provider network problems.
- **CMS must work closely with state regulators to address network adequacy concerns that are most relevant to each state (and the individual health plan service areas within each state).**
- **The College also supports the enhanced requirements for the inclusion of essential community providers (ECP) such as federally qualified health centers, Ryan White HIV/AIDS providers and safety net hospitals; however, the 30% ECP threshold proposed in CMS' February 4 letter should be a minimum, and QHPs should be encouraged to incorporate additional ECPs to meet the needs of patients in the service area. CMS and state regulators 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.**

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

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

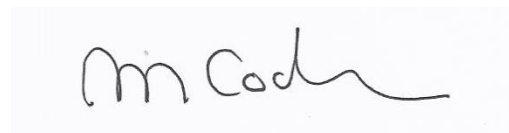
Improving the appeals process: With reports surfacing that many qualified health plans are offering tight provider networks, tiered networks, stringent prescription drug formularies and other cost-cutting schemes, it is important that regulators work to ensure that consumers are able to access a fair and responsive appeals process. State regulators should monitor and enforce ACA and state laws that

facilitate access to an appeals process for claims denials, formularies, and others. In the event that a plan's network is deemed inadequate, health plans must **create an appeals process to authorize in-network cost-sharing if a medically necessary service is not available within the network but is available from an out-of-network physician willing to accept terms of the service. This exception is permitted for preventive services<sup>iv</sup>, but it should be expanded to include other essential health benefits.**

Further, state and federal regulators and other stakeholders must closely monitor formularies and other benefit design features to ensure that coverage does not exclude patients with complex chronic conditions undergoing therapy, including patients with cancer, transplants, mental health treatment, HIV/AIDS, and hepatitis C. Such limited formularies 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 supports CMS' increased attention to tracking formularies and urges state regulators to work with their federal counterparts to monitor whether formularies and benefit packages violate the intent of the law.

ACP appreciates the role of state insurance regulators to monitor and enforce the broad and complex reforms established by the ACA. Physicians offer their support towards the mission of NAIC to help ensure that patients have access to their preferred physician and are enrolled in health insurance coverage that is fair, comprehensive, and affordable.

Sincerely,

A handwritten signature in black ink, appearing to read "M Cooke", on a light blue background.

Molly Cooke, MD FACP  
President  
American College of Physicians

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<sup>i</sup> 45 CFR 156.230

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

<sup>iii</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.

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

## APPENDIX C



February 11, 2014

Karen Ignagni  
President and Chief Executive Officer  
America's Health Insurance Plans  
601 Pennsylvania Ave., NW  
South Building  
Suite 500  
Washington, D.C. 20004

Dear Ms. Ignagni,

The American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine specialists (internists), related subspecialists, and medical students, writes to express our interest in working with America's Health Insurance Plans (AHIP) members to achieve the Affordable Care Act's goal of expanding access to affordable, high-quality health insurance. As the major ACA coverage provisions are implemented over the years ahead, ACP believes that physicians and health insurers can find common ground on efforts to ensure that patients receive health care of the highest value and quality. Not only is this imperative from a patient health standpoint, but also necessary if our nation is to curb rising health care costs.

The College is appreciative of AHIP member efforts to build and encourage innovative health care delivery models such as the patient-centered medical home, which facilitates better care coordination and emphasizes the prevention of pernicious medical conditions.

As the ACA is implemented throughout the nation, ACP hopes that AHIP member plans can continue to work with physicians to ensure that patients are able to access a wide range of high-quality physicians, that consumers have the tools and information they need to make an educated decision about which health plan to purchase, and that health plans work with stakeholders to ensure that patients are able to access the physicians, hospitals, medical services, and prescription drugs that are necessary to their care.

The College hopes that our nation's health plans will continue to work with physicians and other stakeholders to achieve the goals of expanding high-quality, high-value health coverage to all. Below is

a list of recommendations ACP respectfully offers to AHIP to improve the implementation of this historic law.

### **Recommendations**


- **Health plans should be transparent in the criteria they consider when developing provider networks. Health plans should consider a range of 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, training, or excluding a physician from a plan’s network.** Providers and their patients should be given advance notice that network changes are being considered so that they may comment on and challenge alterations as necessary; all network selection and deselection decisions should be on record and the physician should be provided with detailed reasons as to why their contract was terminated. While limited networks can be a means of steering patients to high-value physicians, they should not be used only to tamp down costs.
- **QHPs should update their online provider directories in “real-time” upon receipt of new information to ensure accuracy when the potential enrollee is shopping for and selecting a qualified health plan. This will enable patients to know that their preferred physician or hospital is within their chosen plan’s network and protect them from unpredictable out-of-pocket costs for out-of-network services.** As you know, the December 17, 2013 interim final rule urged QHPs to provide the most current online directory to marketplace plan shoppers and treat out-of-network physicians as in-network if they were listed in the QHP’s in-network provider directory at the time of the patient’s enrollment. ACP strongly encourages health plans to adopt this exception and consider expanding it beyond the “beginning months” window outlined in the regulation.
- **QHPs should establish “health care provider hotlines” to connect physicians, hospitals and other providers to QHP representatives to answer questions, verify patient enrollment, and obtain other information.** Physicians need to be able to verify patient enrollment at the time of service as well as receive important information about a plan’s cost-sharing requirements, fee schedules, claims processing, and dispute resolution information. Health plans should work to provide an accessible means of physician and health plan communication, either through an online portal or telephone that will make it easy for physicians to efficiently deliver care to their patients without delay.
- **QHPs should provide real-time notification of when a patient enters the 90-day grace period upon enrollment verification check by a physician or their staff. Notification should provide information on what month of the grace period the enrollee is in.**
- **Physicians play an integral part in the internal and external appeals process, providing evidence that the care or provider access requested is medically necessary. To help expedite**

the appeals process and reduce any potential administrative burden on providers, efforts should be made to ensure that physicians have easy access to necessary appeals documentation and are able to submit them through a variety of means, such as an online portal. Health plans should have 24-hour telephone access for physician-to-physician dialogue with the ability to resolve any clinical or medically necessity issues.

- **QHPs should allow patients to have access to the medication in dispute during the entire formulary exception review process and if granted, that the excepted drug continue to be provided for in subsequent plan years;** this will ensure continuity of care while the appeal is being considered. With increasing use of step therapy and drug tiers, efforts should be made to provide necessary therapies to patients, even when they are awaiting a coverage decision from the health plan or independent external reviewer. We urge health plans to work federal and state regulators to carry out the nondiscrimination safeguards described in the draft 2015 Letter to Issuers in the Federally-facilitated Marketplace issued by the Centers for Medicare and Medicaid Services. These consumer protections will help guarantee that all patients can access medically necessary prescription drugs and other therapies without unreasonable delay or cost.
- **QHPs should be required to expedite the internal and external appeal review process to ensure that provide a decision to the patient and provider/prescriber no later than 24 hours for urgent care situations or 72 hours for non-urgent care situations.**

Although we believe that many of the recommendations we have offered in this letter can and should be voluntarily implemented by your health plan members, we also believe that there is a need for improved oversight from federal and state regulators. We sent the attached letters today to HHS Secretary Kathleen Sebelius and the National Association of Insurance Commissioners with our recommendations relating to regulatory oversight of qualified health plans. ACP appreciates your consideration of the above recommendations. Working together, physicians, health plans, and other stakeholders can achieve the spirit of the Affordable Care Act – drastically reducing our nation’s uninsurance rate and promoting high-quality, high value care for all.

Sincerely,

A handwritten signature in dark ink, appearing to read "M Cooke", with a stylized flourish at the end.

Molly Cooke, MD FACP  
President  
American College of Physicians

## APPENDIX D



February 11, 2014

Scott P. Serota  
President and Chief Executive Officer  
Blue Cross and Blue Shield Association  
1310 G St., NW  
Washington, D.C. 20005

Dear Mr. Serota,

The American College of Physicians (ACP), the largest medical specialty organization and second-largest physician group in the United States, representing 137,000 internal medicine specialists (internists), related subspecialists, and medical students, writes to express our interest in working with Blue Cross and Blue Shield Association (BCBSA) members to achieve the Affordable Care Act's goal of expanding access to affordable, high-quality health insurance. As the major ACA coverage provisions are implemented over the years ahead, ACP believes that physicians and health insurers can find common ground on efforts to ensure that patients receive health care of the highest value and quality. Not only is this imperative from a patient health standpoint, but also necessary if our nation is to curb rising health care costs.

The College is appreciative of BCBSA member efforts to build and encourage innovative health care delivery models such as the patient-centered medical home, which facilitates better care coordination and emphasizes the prevention of pernicious medical conditions.

As the ACA is implemented throughout the nation, ACP hopes that BCBSA member plans can continue to work with physicians to ensure that patients are able to access a wide range of high-quality physicians, that consumers have the tools and information they need to make an educated decision about which health plan to purchase, and that health plans work with stakeholders to ensure that patients are able to access the physicians, hospitals, medical services, and prescription drugs that are necessary to their care.

The College hopes that our nation's health plans will continue to work with physicians and other stakeholders to achieve the goals of expanding high-quality, high-value health coverage to all. Below is

a list of recommendations ACP respectfully offers to BCBSA to improve the implementation of this historic law.

### **Recommendations**

- **Health plans should be transparent in the criteria they consider when developing provider networks. Health plans should consider a range of 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, training, or excluding a physician from a plan’s network.** Providers and their patients should be given advance notice that network changes are being considered so that they may comment on and challenge alterations as necessary; all network selection and deselection decisions should be on record and the physician should be provided with detailed reasons as to why their contract was terminated. While limited networks can be a means of steering patients to high-value physicians, they should not be used only to tamp down costs.
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