



Sound Policy. Quality Care.

January 30, 2023

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9899-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024**

Dear Administrator Brooks-LaSure,

The Alliance of Specialty Medicine (the “Alliance”), representing more than 100,000 specialty physicians from sixteen specialty and subspecialty societies, is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write to express ongoing concern with network adequacy in Marketplace plans and other issues.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges  
*Network Adequacy (§ 156.230)*

In this rule, CMS proposes to require all Exchange plans to comply with its existing standards for network adequacy, including those that have not used a provider network. The Alliance appreciates that all plans would be subject to network adequacy standards. However, we remain concerned that ***CMS’ existing network adequacy standards fail to meaningfully ensure robust access to specialty and subspecialty medical care.***

The challenge of narrow and restrictive provider networks in Exchange plans has been the subject of considerable study. One recent analysis, for example, found that 78 percent of Marketplace plans use a restrictive network and limit out-of-network coverage.<sup>i</sup> Despite this, CMS has not meaningfully revised its quantitative standards to improve consumer access, particularly when it comes to specialty medical care. For example, CMS’ time/distance standards only apply to some specialists and not subspecialists.<sup>ii</sup>

***Most consumers do not realize the limitations of their plan’s provider network until they are faced with a critical need for specialty medical services and the physicians who deliver them.*** Only then do

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the barriers to specialists and subspecialists become apparent. As a result, many patients forego critical, medically necessary specialty care because the obstacles to acquiring treatment are too significant. Anecdotally, some specialty practices have reported that patients have contacted them to “negotiate” cash payment for services because an in-network specialist is too far away, and they do not have out-of-network benefits. In these situations, the patient’s insurance is useless — it pays nothing, nor does it provide the benefit of an insurer-negotiated rate.

For many years, the Alliance has requested that CMS take action to improve its network adequacy standards in both the Exchanges and Medicare Advantage (MA). Specifically, we have recommended that CMS:

- Require plans to accurately identify physician specialties and subspecialties when calculating network adequacy using the Healthcare Provider Taxonomy code set developed by the National Uniform Claims Committee (NUCC),<sup>iii</sup> which distinguishes between specialty and subspecialty physicians.
- Develop Quality Rating System (QRS) measures for plans that:
  - Account for specialty and subspecialty care, which may include aligning QRS measures with physician-level performance metrics in CMS’ Quality Payment Program; and
  - Tie maintaining an adequate network to a health plan’s quality rating.
- Require plans to provide detailed information on the cause for exclusion or termination from the network, including options for entering or re-entering the network.
- Require plans to maintain accurate, real-time provider directories that include specialty and subspecialty designations.

***We again ask you to consider these recommended improvements to ensure consumers in Exchange plans have access to a robust network of physicians, including all specialty and subspecialty providers.***

We believe that this policy goal carries even greater weight now as we watch the responses of health plans to the implementation of the *No Surprises Act*. We are aware of an increased number of instances of health plans abruptly terminating long-standing provider contracts or demanding exorbitant decreases in rates from physicians given the *No Surprises Act* regulations have given health plans an incentive to pay providers out-of-network at the extremely skewed, non-market based Qualifying Payment Amount (QPA) rate rather than reimburse for services at a mutually agreed upon contract-based market rate. Regardless of the choices CMS makes in the context of the *No Surprises Act*, it is imperative that the Agency implement Exchange plan safeguards against this dynamic by improving the network adequacy standards so patient will be ensured access to all specialty and subspecialty providers.<sup>iv</sup>

#### *Standardized Plan Options (§ 156.201)*

We appreciate CMS’ proposal that would require plans to place all covered drugs in the appropriate cost-sharing tier unless there is an “appropriate and non-discriminatory basis” (i.e., a clinical basis) for placing the drug in the specialty tier. Specifically, CMS would require issuers to:

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- (1) Place all covered generic drugs in the standardized plan options' generic drug cost-sharing tier or the specialty drug tier if there is an appropriate and non-discriminatory basis for doing so; and
- (2) Place brand name drugs in either the standardized plan options' preferred brand or non-preferred brand tiers or specialty drug tier if there is an appropriate and non-discriminatory basis for doing so.

The agency explains it has become "aware of concerns that issuers may not be including specific drugs at appropriate cost-sharing tiers for the standardized plan options; for example, some issuers may be including brand name drugs in the generic drug cost-sharing tier, while others include generic drugs in the preferred or non-preferred brand drug cost-sharing tiers." According to a fact sheet on the rule, CMS' proposal is intended "to reduce the risk of discriminatory benefit designs, to minimize barriers to access for prescription drugs, and to reduce the risk of consumer confusion for those enrolled in these plans."

Many patients with chronic, complex health conditions rely on medications to manage their disease. We agree with CMS that consumers should be able to "understand the difference between generic and brand name drugs, and that it is reasonable to assume that consumers expect that only generic drugs are covered at the cost-sharing amount in the generic drug cost-sharing tier, and that only brand name drugs are covered at the cost-sharing amount in the preferred or non-preferred brand drug cost-sharing tiers." ***We urge CMS to finalize this proposal.***

Further, in determining "if there is an appropriate and non-discriminatory basis" for including a generic or brand name drug in a specialty tier, ***CMS should require plans to publicly post the clinical evidence used in making this determination so that stakeholders may review and, if necessary, provide feedback to the plan.***

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We appreciate the opportunity to provide feedback on the proposals in this rule that aim to improve access to specialty and subspecialty care. Should you have any questions or would like to meet with the Alliance to discuss these recommendations further, please contact us at [info@specialtydocs.org](mailto:info@specialtydocs.org).

Sincerely,

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<sup>i</sup> <https://avalere.com/press-releases/2020-exchange-plan-networks-are-the-most-restrictive-since-2014>

<sup>ii</sup> <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf>.

Note that CMS' [2024 Draft Letter to Issuers](#) explains that "The approach for time and distance standards remains unchanged from 2023" and refers plans to review the 2023 Letter to Issuers.

<sup>iii</sup> <https://taxonomy.nucc.org>

<sup>iv</sup> Tepper, Nona, "Coming to a contract negotiation near you: the No Surprises Act," Modern Healthcare, August 3, 2022 (<https://www.modernhealthcare.com/insurance/no-surprises-act-influencing-insurers-rate-setting-plans>, accessed January 19, 2023).

<sup>v</sup> <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-proposed-rule>

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