American Cancer Society ☙ Children's Defense Fund-New York ☙ Community Service Society of New York
Empire Justice Center ☙ Institute for Puerto Rican and Hispanic Elderly
Make the Road New York ☙ Medicare Rights Center
Metro New York Health Care for All Campaign ☙ New Yorkers for Accessible Health Coverage ☙
New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority

March 10, 2015

Ms. Donna Frescatore
Executive Director
New York State of Health
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Mr. Troy Oechsner
Deputy Superintendent for Health
NYS Department of Financial Services
One Commerce Plaza
Albany, NY 12257

RE: HCFANY Recommendations for NY State of Health 2016 Plan Invitation

Dear Ms. Frescatore and Mr. Oechsner:

Health Care for All New York (HCFANY) is a statewide coalition of over 170 organizations seeking to secure affordable, quality health care for all New Yorkers. HCFANY applauds the NY State of Health Marketplace (NYSOH) for successfully enrolling over two million New Yorkers in quality, affordable health coverage. We write to thank you and your staff for your dedication to building the nation's leading consumer-friendly Marketplace that offers affordable coverage, high standards for participating plans, and robust consumer protections.

We would like to take this opportunity to offer our insights as you prepare to release the 2016 plan invitation for participating plans on the Marketplace. Some of these recommendations build upon our correspondence concerning last year's procurement (*See* HCFANY letter dated June 20, 2014); other recommendations are new, based upon consumer experiences reported to our coalition this past year. Our comments fall into two categories. The first involves network considerations; and the second concerns enhanced consumer protections.

I. Recommendations to ensure robust, consistent provider networks and accessibility of out-of-network providers

Consumers often comment that a transparent, accessible and robust network of providers is amongst their top priorities for insurance coverage. Currently, New York's individual market does not offer out-of-network coverage, making network adequacy concerns all the more

paramount. In the 2016 Marketplace plan procurement process, HCFANY urges the State to consider four steps to improve networks for New Yorkers, including: (1) requiring all plans to offer out-of-network coverage options at the Silver and Platinum levels; (2) adopting standards for transparency and accessibility of plan network information; (3) adopting policies to protect consumers from changing networks and formularies; and (4) convening a multi-stakeholder advisory committee to strengthen network adequacy requirements, review and enforcement.

1. ***Consider requiring all Marketplace plans to offer out-of-network coverage options.***

Currently, consumers have no option to buy out-of-network coverage in New York's individual market. Consumers who lost such coverage when their standardized individual plans were cancelled at or after the end of 2013 were only given a two year extension for non-NYSOH plans, which will terminate December 31, 2015. Thousands of others who relied on such coverage for many years in the sole proprietor and freelancer markets have now lost the option entirely. For some consumers, the shift away from out-of-network coverage has disrupted long term trusted provider relationships and resulted in diminished quality of care. New York has transitioned from being a state that offered broad coverage options to individuals with serious health conditions to one of just three states with the most restrictive out-of-network options. Many consumers feel that they are unfairly disadvantaged as compared to their counterparts in the small and large group markets, where out-of-network options are routinely available.

To address consumer concerns, HCFANY believes that the 2016 plan invitation should require all insurance carriers to offer options for out-of-network coverage at the Silver and Platinum levels. Coverage at the Silver level is necessary because individuals who need subsidies to buy coverage should not have to choose between subsidies and access to the most appropriate specialists regardless of network affiliation. Coverage at the Platinum level is appropriate because many consumers who are most interested in out-of-network coverage buy platinum plans. The coverage can be priced fairly to reflect the increased costs associated with the out-of-network benefit, and can be structured so as not to increase costs to consumers who do not choose the benefit.

Requiring out-of-network coverage options on the Marketplace will ensure that New Yorkers can get the care they need, at an extra cost, from accessible and trusted providers.

2. ***Consider establishing strong disclosure standards regarding to plan networks.***

Consumers enrolling through the Marketplace express concerns that they lack access to comprehensive and clear plan network information necessary to choose a plan that meets their needs. The Marketplace currently does not present network information in a way that allows consumers to make apples-to-apples comparison of plan networks when they are selecting plans. Instead, the Marketplace provides links to health plan websites that use a multiplicity of display formats, many of which are confusing. To get a comprehensive picture of a plan's network requires use of numerous tedious drop-down filters for each individual provider search which makes the process particularly onerous. Marketplace enrollees must make critical and financially significant choices between health plans without some of the most basic and essential details, such as how many providers or hospitals are in a plan's network. While HCFANY

understands that the Marketplace is building a uniform provider network portal, an undertaking we endorse and applaud, that portal is not yet available.

During the interim period prior to launch of a provider network portal on the Marketplace, HCFANY urges the State to improve access to plan network information by: (1) requiring plan links to networks be standardized in their displays; and (2) adopting strong transparency standards with regard to plan network information.

First, the State should consider adopting standard specifications for all provider directories. Standardized specifications should apply to Qualified Health Plans, Medicaid and CHPlus plan directories, all of which should be linked to from the NYSOH website (currently, links to Medicaid and CHPlus plan provider directories are not posted on the NYSOH website). Consumer and Navigators routinely find that plan provider directories are either incorrect or inconsistent with information available from physicians' offices. To address this concern, the standardized specifications should require that all provider directories conform with the new State law which requires network changes to be updated at least within 15 days. *See* N.Y.S. Ins. L. §3217-a(17).

As part of the plan certification process, HCFANY urges that the plan's individual provider search functions be required to be consumer-friendly. Many health plan pages are confusing and needlessly onerous for consumers, requiring scrolling down to find formulary and provider search links listed in very small type under each plan name (*See, e.g.* Metroplus website). Additionally, some on-line directories require a burdensome amount of detailed information to find if a doctor is in-network (e.g. Empire requires zip code, state, plan type, and network to retrieve this information). HCFANY recommends looking to Oscar Health's provider search function as a user-friendly model, as it requires only entering a provider's last and first name, specialty, or zip code.

Second, HCFANY recommends the State require certain standardized disclosures with respect to plan networks, to ensure consumers can choose a plan that meets their unique health care needs. Plan networks vary widely by size (e.g. broad vs. skinny vs. super skinny networks), ratio of providers to enrollees, geographic concentration of providers, representation of certain specialty providers, and other factors. Consumers should have ready access to this type of information. HCFANY recommends that all plans be required to provide the following plan network details:

- Network size, including listing the number of total providers, primary care doctors, specialists, and hospitals that are in the network. This information should be posted by county, in addition to overall numbers.
- Number of hospitals, pharmacies, laboratories, and diagnostic facilities by county, and ratio of network hospitals and pharmacies to total hospitals and pharmacies in that county.
- Provider to enrollee ratio for primary care providers and specialists.
- Geographic concentration of primary care providers and specialists. This could be accomplished through providing a mapping function for network providers by zip code,

so that consumers can easily see the concentration of providers in close proximity to their home or work (e.g. Oscar Health provider search function).

- A clear indication of whether providers are accepting new patients, including the specific in-network facilities at which providers have openings. Consumers should be able to filter provider search results by those providers accepting new patients, in order to obtain the most accurate picture of network capacity.
- A list of the languages spoken by the provider or its staff.

Further, HCFANY urges the State to clearly post these details for all plans on the NY State of Health Marketplace website, updated on a monthly basis. The Department of Health already publishes much of this information for Medicaid Managed Care Plans, including network size and provider-to-enrollee ratios, in the *All Plan Summary Report for New York State Medicaid Managed Care Organizations*.[1] This report can be used as a model for posting similar information for all plans on the NY State of Health Marketplace. For example, HCFANY recommends the State post a table of total providers by specialty overall and by county for each plan, modeled after Figure 7, Providers by Specialty. The State should also post ratios of providers to enrollees by plan as in Figure 8, Ratio of Enrollees to Providers.

Additionally, HCFANY recommends that the State review and potentially follow the lead set forth recently in the 2016 Proposed Rate Notice issued on February 20, 2015 by the Centers for Medicare and Medicaid Services. (Available at: http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf.) This Notice indicates that CMS is aware of a "range of issues with online provider directories," including listing of physicians who are no longer on contract or who are not accepting new patients. (CMS 2016 Notice at 134). In an effort to address these network adequacy concerns, CMS is requiring that contracted plans:

- regularly communicate with providers to ascertain their availability;
- require their contracted providers to inform the plans of any changes regarding their addresses, phone numbers, and office hours that might affect their availability to patients; and
- develop a protocol to effectively address inquiries/complaints related to denial of access to providers.

CMS has additionally elected to engage in direct monitoring of its contracted plans by: (1) securing a contractor to verify the accuracy of online plan directories; (2) developing a new audit protocol to test the validity and accuracy of online directories; and (3) instituting enforcement actions. (*Id.* at 135).

Other states are also taking steps to improve network provider directories and can provide more strong models for New York to follow. For example, legislation was recently introduced in California (SB 137), to require plans to update provider networks on a weekly basis, to follow a

[1] New York State Department of Health, Office of Quality and Patient Safety. (May 2014). All Plan Summary Report for New York State Medicaid Managed Care Organizations. Available at: http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf

standard provider directory template, and to include information such as languages spoken by clinical staff and a phone and email address for consumers to report inaccuracies.[2]

Adoption of some or all of these measures will greatly improve the consumer experience with their Marketplace coverage options.

3. ***Consider adopting policies to protect consumers from changing networks and formularies.***

HCFANY recommends the State require the plans to establish policies to protect consumers from changing networks and to encourage network stability. Consumers complain that provider networks change too often, causing unnecessary disruptions in continuity of care.[3] Some consumers sign up for Marketplace plans based on information about providers' network status and drug formularies that is inaccurate from the outset. HCFANY recommends the State consider three remedies to this problem: (1) mandate that plans do not change formularies or terminate providers during the year (with exceptions provided below); and (2) provide for an extended transition period of one year to maintain access to providers or drugs at in-network costs.

First, HCFANY urges the State to require plans to have provider contracts run for the calendar year, concurrent with the plan years for plans in the individual market, with plans only able to terminate a provider in the event of malfeasance or when patient safety issues are presented. Similarly, drugs should retain their formulary status for the entire plan year, with the exception of adding new prescription drugs or removing those proven dangerous and taken off the market by the FDA.

Second, the State could require plans to offer an extended transition period of one year for consumers to maintain access to critical providers and prescription medications after a provider leaves the network or a formulary changes. New York State Law currently requires all insurance carriers, both on and off the Marketplace, to offer a 90-day transition period if an enrollee's provider leaves the network while they are undergoing a course of treatment, as long as the provider agrees to accept the original negotiated fee.[4] However, a 90-day period is not sufficient if the provider is critical to an enrollee's care. The State should consider requiring NYSOH plans to extend the transition period to allow consumers to continue receiving care from a critical provider until the end of the plan year, at which point the consumer will have the opportunity to switch to a more appropriate plan as needed.

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[2] *See* CA SB 137, available at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_0101-0150/sb_137_bill_20150126_introduced.htm.

[3] Network changes can happen on a massive scale. For example, in December 2013 United Healthcare announced it would cancel contracts with over 2,000 doctors, affecting over 8,000 consumers. *See* Kaiser Health News. *United Healthcare Dropping Hundreds of Doctors from Medicare Advantage Plans.* December 1, 2013. Available at: http://kaiserhealthnews.org/news/medicare-advantage-unitedhealthcare-narrow-networks-doctors/

[4] *See* NY PH Law §4403 (6)(e)(1).

4. ***Consider convening a multi-stakeholder advisory committee to review network adequacy standards and make recommendations to improve standards, monitoring and enforcement.***

HCFANY encourages the Department of Health, the Department of Financial Services, and Marketplace staff to convene a multi-stakeholder advisory meeting for the purpose of updating and strengthening New York's network adequacy standards. Three areas that could be addressed by the committee are: (1) network adequacy requirements; (2) appointment availability standards; and (3) network and provider availability monitoring and enforcement activities.

First, HCFANY is concerned that the network adequacy requirements for Marketplace plans are insufficiently guarantee robust networks for consumers. State officials have informed us that plans are required to have, at minimum, three Primary Care Providers per county and two specialists per county.[5] Marketplace plans currently have no requirements for provider-to-enrollee ratios. In contrast, New York's Medicaid Managed Care model contract requires that plans have no more than 1,500 enrollees per physician.[6] Without explicit standards for provider-to-enrollee ratios, Marketplace plans in larger regions may not have a sufficient number of providers to meet enrollees' needs. HCFANY recommends, for example, that the network adequacy requirements include explicit provider-to-enrollee ratios for all Marketplace plans—Qualified Health Plans, Child Health Plus and Medicaid Managed Care.[7]

Second, HCFANY is concerned that Marketplace plans are not required to comply with specified appointment availability standards. In contrast, New York's Medicaid Managed Care model contract also includes standards related to appointment availability for routine and urgent care and in office waiting times.[8] For example, patients must be able to make an appointment within 24 hours for urgent care, within 72 hours for sick visits, and within 4-6 weeks for non-urgent specialist care. Appointment waiting times are limited to one hour for enrollees. The Marketplace should add similar standards for appointment waiting times, because provider networks are only meaningful if consumers can access services and treatments within a reasonable timeframe.

Third, HCFANY is concerned that Marketplace plans are not robustly monitored for network adequacy. The State should conduct an audit of network adequacy similar to the State's

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[5] *See* 2015 NYSOH Invitation to Participate, page 22/23. While the provider network adequacy standards for PCPs and Specialists indicate that "more may be required based on enrollment or geographic accessibility," the standards do not include explicitly stated provider-to-enrollee ratios.

[6] *See* NYS Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract. (March 1, 2014. Section 21.12. Available at: http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

[7] Enrollee-to-provider ratios and appointment waiting times were highlighted as best practices for network adequacy highlighted in a recent 50-state survey and report by consumer representatives to the National Association of Insurance Commissioners. *See* Health Management Associates. (November 2014). *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market.* Available at: http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf.

[8] *See Ibid.* Sections 15.2 and 15.4.

Medicaid Managed Care Access and Availability Survey conducted by the External Quality Review Organization (EQRO).[9] The audit could assess factors such as plan compliance with appointment availability and wait time standards. HCFANY further recommends the State explore enforcement mechanisms, such as fines, for plans that do not comply with transparency requirements and/or network adequacy standards.

To further explore these and other recommendations, HCFANY urges the state to convene a multi-stakeholder advisory committee. The committee could identify model network adequacy standards, such as those mentioned above, and inform the development of policies and protocols to monitor and enforce standards in time for the 2017 plan invitation.

II. Other recommendations to strengthen the 2016 Plan Invitation for the NY State of Health Marketplace.

1. *Explore ways to further reduce the deductible for Silver CSR1 plans on the NYSOH Marketplace.*

HCFANY applauds NYSOH for reducing the deductible for Silver Cost Sharing Reduction Level 1 (CSR1) plans for people with incomes between 200% and 250% of the federal poverty level to $1,200 per year for the 2015 plans year. We urge the State to consider reducing the deductible for CSR1 plans even further in the 2016 plan invitation. HCFANY recognizes that the Affordable Care Act specifies that Silver CSR1 plans have an actuarial value of 73%, which makes it challenging to further reduce the deductible.

HCFANY would like to raise two concerns. First, the $1,200 deductible remains a significant deterrent for many potential CSR1-eligible enrollees; one that may adversely affect NY State of Health enrollment. Second, NYSOH enrollees below 200% of poverty (who were formerly eligible for Cost Sharing Reductions at the CSR2 and CSR3 level) will soon be eligible for the Basic Health Program where there is no deductible at all. With the rollout of BHP, CSR1 enrollees will experience a sharp cliff should their incomes move above 200 percent of the federal poverty level.

To address these concerns, HCFANY urges the State to explore additional options to lower the CSR1 deductible while still complying with federal Actuarial Value requirements. For example, perhaps the State could increase the Maximum Out-of-Pocket (MOOP) limit for the CSR1 plans ($5,200) to the level of a silver plan ($5,500), and likewise reduce the CSR1 deductible by $300. Even a $300 savings in up-front health insurance costs could make a significant difference for lower-income enrollees who are struggling to pay health care costs alongside rent, utilities, and other expenses.

2. *Ensure robust coverage, particularly for women, LGBTQ people and people with chronic conditions.*

[9] *See* New York State Department of Health, Office of Quality and Patient Safety. (May 2014). All Plan Summary Report for New York State Medicaid Managed Care Organizations, pg. 13. Available at: http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf

HCFANY urges the State to take steps to ensure that plans do not discriminate against or discourage enrollment by certain groups of individuals. To this end, the 2016 Plan Invitation should include the following: (1) an explicit reference to the recent NYS Guidance barring insurers from excluding coverage for transgender-related care;[10] (2) language that prohibits plans from discriminatory formulary design; and (3) a requirement that plans provide to enrollees information about the Ryan White AIDS Drug Assistance Program.

First, HCFANY applauds the Department of Financial Services for issuing guidance that prohibits commercial insurers from denying medically necessary treatment for gender dysphoria. The Non-Discrimination section of the 2016 Plan Invitation should contain an explicit reference to this requirement and the new guidance, to help ensure compliance by NY State of Health plans.

Second, HCFANY urges the State to prohibit discriminatory formulary design in the Non-Discrimination section of the Plan Invitation. Consumers with certain chronic conditions, including HIV, Hepatitis C, and multiple sclerosis, have reported that some plans charge higher cost sharing for drugs associated with their chronic condition, or simply don't include them in formularies. Consequently, some consumers have reported difficulties in maintaining their drug regimens.[11] To address this concern, we urge the State to adopt formulary non-discrimination language in the 2016 Plan Invitation that is modeled after language in the U.S. Department of Health and Human Services' 2016 Proposed Notice of Benefit and Payment Parameters. [12] The Preamble to the proposed rule states "if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions." This approach was adopted in the final rule.[13]

Third, HCFANY recommends the State require QHP issuers to provide information to enrollees, and prospective enrollees, about the potential availability of assistance in paying for certain high-cost medications and premiums from the Ryan White AIDS Drug Assistance Program. The Kaiser Family Foundation study (referenced above) also reported that participants were largely unaware of Ryan White premium assistance, and no participants in the New York focus group received this premium support. Requiring insurers to provide this information will ease the financial burden experienced by enrollees who are HIV+ or have AIDS.

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[10] Department of Financial Services. Re: Health Insurance Coverage for the Treatment of Gender Dysphoria. December 11, 2014.

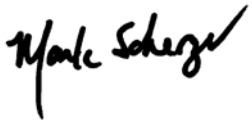
[11] A recent multi-state study found evidence that some insurers may be using benefit design to dissuade sicker individuals from joining their plans, by charging higher cost-sharing for drugs associated with HIV. (*See* Jacobs, D.B. and Sommers, B.D. (January 29, 2015). Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace. N Engl J Med; 372: 399-402). A New Yorker in a recent Kaiser Family Foundation focus group study skipped his HIV medication for a day after his pharmacy told him it cost almost $2,000. (*See* Kates, J. et. al., "Health Insurance Coverage for People with HIV Under the Affordable Care Act: Experiences in Five States," Issue Brief from the Kaiser Family Foundation, December 2014, accessed at http://kff.org/hivaids/issue-brief/health-insurance-coverage-for-people-with-hiv-under-the-affordable-care-act-experiences-in-five-states/

[12] 79 Fed. Reg. 70723 (Nov. 26, 2014)

[13] 79 Fed. Reg. 80 FR 10749 (Feb. 27, 2015)

We appreciate your consideration of our comments and recommendations as you prepare to release the 2016 Plan Invitation. If you have any questions, please contact Mark Scherzer at mark.scherzer@verizon.net or at (212) 406-9606, or Amanda Peden at apeden@cssny.org or at (212) 614-5541.

Very truly yours,



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