January 12, 2015

National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001

RE: Revisions to Managed Care Plan Network Adequacy Model Act #74

To Whom it May Concern:

As the National Association of Insurance Commissioners (NAIC) considers revisions to the Managed Care Plan Network Adequacy Model Act, we urge you to address the accessibility of family planning and other preventive sexual and reproductive health care—particularly to low-income and other underserved communities. I am pleased to submit the following comments on behalf of the Guttmacher Institute, a nonprofit organization dedicated to advancing sexual and reproductive health worldwide through research, policy analysis and public education.

To facilitate access to needed sexual and reproductive health care and benefit individuals served by the network of publicly supported family planning providers, we encourage NAIC to consider doing the following in its revisions to the Model Act:

- Add measures to the list of reasonable criteria used to determine network adequacy to help ensure enrollees’ timely access to the full scope of family planning and related services;
- Explicitly define “essential community provider” (ECP) to include all safety-net family planning centers and incorporate requirements for contracting with ECPs into the network adequacy standards; and
- Disallow carriers from refusing to contract with providers based solely on the services they offer, particularly with regard to family planning centers that also offer abortion services or are affiliated with abortion providers.

Please see the attached comments submitted to the Centers for Medicare and Medicaid Services for further detail; network adequacy and essential community providers are discussed on pages 2-4.

We hope you find these comments useful as you finalize updates to the Model Act. For additional information about the issues raised in this letter, please contact Kinsey Hasstedt in the Institute’s Washington office by phone at 202-296-4012 or by email at khasstedt@guttmacher.org.

Thank you for your consideration.

Sincerely yours,

Rachel Benson Gold
Vice President for Public Policy
December 22, 2014

The Honorable Sylvia Mathews Burwell  
Department of Health and Human Services  
200 Independence Ave. SW  
Washington, DC 20201

RE: CMS–9944–P (Patient Protection and Affordable Care Act; HHS Notice of Benefits and Payment Parameters for 2016)

Dear Secretary Burwell:

On November 26, 2014, the Centers for Medicare and Medicaid Services (CMS) released its proposed rules on payment parameters, standards for qualified health plans (QHPs) and network adequacy, and other provisions related to implementing the Affordable Care Act (ACA) in 2016 and beyond. I am pleased to submit the following comments on the proposed rules on behalf of the Guttmacher Institute, a nonprofit organization dedicated to advancing sexual and reproductive health worldwide through research, policy analysis and public education.

The proposed rules contain several provisions that will greatly facilitate access to needed sexual and reproductive health care and benefit individuals served by the network of publicly supported family planning providers that has long been a critical source of high-quality, affordable care for the largely low-income individuals who are seeking coverage through the marketplaces.

First, we appreciate the inclusion of the network adequacy standards from the 2015 Letter to Issuers in the Federally Facilitated Marketplaces, as well as clarification that all safety-net family planning centers are considered essential community providers (ECPs). CMS should further clarify that these centers may not be discriminated against based solely on the services they provide. Further, given the importance of family planning centers to ensuring enrollees' meaningful access to reproductive health care, we strongly urge CMS to further strengthen the ECP contracting requirements for QHP issuers, and to include specific, measurable criteria in defining meaningful network adequacy standards.

Second, we appreciate that CMS has addressed the specific accounting mechanisms the ACA requires of issuers that opt to cover abortion beyond the limited circumstances of rape, incest and when a woman’s life is endangered. We urge CMS to ensure that implementation of this requirement is seamless to enrollees and streamlined for issuers. The final rules should clarify that issuers are not required to provide any notice to enrollees that itemizes abortion coverage within their premiums, and that enrollees can pay their entire monthly premium—including the proportion designated for coverage of abortion services—with a single payment transaction.

Third, we urge CMS to incorporate into these regulations and clarify previous guidance on the ACA’s preventive services provision to ensure all QHPs are compliant with this provision, particularly the guarantee of coverage without cost-sharing of contraceptive services and supplies. In particular, we thank CMS for requiring health plans to publish an up-to-date, accurate and complete list of all covered drugs on its formulary drug list, and suggest issuers be required to denote all “preventive drugs” their plans cover at zero cost, including all Food and Drug Administration (FDA)–approved contraceptive drugs and
devices. CMS should also ensure that all contraceptive methods and related care are consistently accessible without cost-sharing to enrollees.

Finally, we recommend that women who become pregnant be eligible for a special enrollment period to select or change health plans in order to best meet their changing health care and provider needs.

**Network Adequacy**

Because coverage is a hollow promise without access, QHPs must be required to adhere to meaningful network adequacy standards that ensure a number and geographic distribution of providers sufficient to meet the full range of enrollees’ covered sexual and reproductive health needs of in a timely manner. Guttmacher Institute analyses show that providing enrollees with that access will be difficult, if not impossible, unless QHP networks include safety-net health centers that provide family planning services: Nationwide, these providers serve 44% of all poor women who obtain contraceptive care, and 34% of low-income women (women with incomes between 100% and 250% of poverty) obtaining this care.¹ Moreover, 63% of women consider the safety-net provider they visit for family planning services their usual source of medical care.

We support the inclusion of the network adequacy standards articulated in the 2015 Letter to Issuers in the Federally Facilitated Marketplaces (FFM) into the rules applying to federally facilitated marketplaces for 2016. We recommend that CMS not only urge, but actually require, state-based marketplaces to adhere to the same standards when examining network adequacy, so long as the federal standards are considered a floor and states with more robust network adequacy standards—particularly with regard to contracting with ECPs—are encouraged to maintain if not strengthen those standards.

As CMS further defines meaningful network adequacy standards that should serve as a required minimum for all QHPs, we recommend those standards account for:

- availability of providers offering the full range of family planning and related services on-site, without requiring a referral;
- wait time for an appointment, and the availability of same-day appointments for family planning and other time-sensitive care;
- distance and travel time to an in-network provider; and
- availability of providers that are taking new patients.

Safety-net family planning centers, such as those that receive funding through the Title X national family program, will surely prove vital partners for QHPs in satisfying these important considerations. According to data collected by the Guttmacher Institute, more than half of safety-net family planning centers offer at least 10 types of reversible contraceptive methods on-site, and two-thirds offer some form of highly effective long-acting reversible contraception (i.e., IUDs or implants).² The average wait time

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for an initial visit at these providers is approximately five days, and four in 10 offer same-day appointments to contraceptive clients. Further, in 2010, 82% of all U.S. counties had at least one safety-net health center providing family planning services; 72% of counties had at least one Title X–supported center.³

**Essential Community Providers**

Given the importance of ECPs to meeting the family planning and associated sexual and reproductive health needs of low-income individuals and to promoting enrollees’ continuity of care, we commend CMS for clarifying in the preamble to the proposed rules that all safety-net health centers providing family planning services—regardless of whether they qualify for the 340B program or receive funding through the Title X national family planning program—are considered ECPs. We further urge CMS to include this definition, along with the comprehensive table of ECP provider-type definitions, in the text of the final regulation to help ensure that women who rely on these providers are able to access the family planning and other health services they need.

Moreover, existing marketplace regulations state that a QHP “may not be prohibited from contracting with any essential community provider.” This protection is intended to prevent attempts by policymakers to discriminate against safety-net providers, particularly family planning centers that might also offer abortion services or be affiliated with such providers. Indeed, state policymakers in Arizona, Indiana and Texas have moved to exclude safety-net family planning providers from being eligible to participate in Medicaid programs for this reason. To ensure states place no such limitations on private plan networks, CMS should, in line with the existing nondiscrimination provision, clarify that states cannot narrow the definition of family planning ECPs from CMS’s own definition, provided in this rule. CMS should also clarify that QHP issuers are prohibited from excluding or limiting the participation of family planning ECPs because of the services they provide.

We agree with CMS that specifying a quantitative standard for QHPs’ contracting with ECPs will help ensure meaningful access to sexual and reproductive care and other health services. We strongly urge CMS to continue to increase the minimum ECP contracting standard as it did from 2014 to 2015, when the minimum threshold increased from including 20% of available ECPs in each plan’s service area to 30%. CMS should also specify that whatever quantitative standard it sets in a given plan year is a minimum that issuers are encouraged to exceed.

Further, the final rules should require QHP issuers to establish “good faith” contracts with—not just offer such contracts to—at least one provider per major ECP category in each county, where that is possible. CMS should clarify that good faith contract terms must include reimbursement at generally applicable rates not only in the preamble, but also in the regulation text. These contracts should be required to include all of the QHP-covered services that the ECP offers.

We believe there is no need to give issuers the option of providing a narrative justification in lieu of meeting these standards. However, issuers unable to meet the requirement because they may serve counties that have no safety-net family planning providers should then need to provide a narrative justification detailing how enrollees will still be able to obtain family planning and other services.

As with the network adequacy standards more broadly, we urge CMS to apply ECP contracting standards to all QHPs, not only those in the FFM. Going forward, continued oversight and enforcement of issuers’

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compliance with these standards will be critical to guaranteeing enrollees’ timely access to high-quality family planning and other care. CMS should issue federal regulations providing for enforcement by federal and state governments as appropriate.

Segregation of Funds for Abortion Services

If an issuer opts to cover abortion care beyond the narrow circumstances of rape, incest and life endangerment, then the ACA expressly requires the issuer to establish specific accounting mechanisms. The issuer must create two separate accounts into which enrollees’ premium payments are deposited: one from which any abortion claims (beyond instances of rape, incest or life endangerment) would be paid, and another comprising the vast majority of enrollees’ premium dollars, from which all other claims would be paid. As the proposed rules point out, the ACA does not require issuers to notify consumers about the proportion of their premium payment that will be held in a separate account for coverage of abortion services, and the law allows consumers to pay the full amount of their premium—including the proportion going toward abortion care—in a single transaction.

If an issuer chooses to notify enrollees of the amount of their premium that will be separated out for abortion coverage, this may be done in any number of ways. We thank CMS for clarifying in the preamble that there is no single permitted way to do so and for offering examples, particularly that issuers may use a single itemized bill that appropriately separates costs. We urge CMS to include this non-exhaustive list of options in the text of the final rules, not just the preamble, and to additionally clarify that in accordance with the ACA, issuers are not compelled to provide any such itemized notice to enrollees. Indeed, some states have offered guidance to their issuers that no such notice is required, and it should be made clear that this guidance is acceptable so as to not unduly add to the administrative burden of providing coverage of abortion.

We similarly thank CMS for underscoring in the preamble that issuers may use a single transfer of funds for the full amount of an enrollees’ premium payment—including the proportion going toward abortion—and recommend that this clarification be included in the text of the final rules themselves. This is in line with current insurance industry practices, and is important to ensuring that consumers seeking abortion coverage are not subject to unnecessary and cumbersome accounting practices.

Preventive Services Coverage

The current regulations require QHP issuers to submit their formulary drug list to the exchange, state or Office of Personnel Management, as appropriate, to ensure they are compliant with the Secretary’s definition of essential health benefits (EHBs). The regulations also require QHP issuers to provide information about the full set of services they cover. This provides an opportunity to ensure that QHPs are compliant with the preventive services provision of the ACA, which requires coverage without cost-sharing of a range of services including contraceptive services, supplies and counseling. To do so, CMS should require issuers to identify all drugs and services that are categorized as “preventive” (i.e., those required to be covered without cost-sharing under the ACA’s preventive services requirement) within their formularies and other appropriate plan documents.

These changes would enable the appropriate regulatory agency to deny certification of a QHP if it is not entirely compliant with the law. Moreover, CMS should require that formularies and other relevant plan documents be made readily accessible not only to enrollees, but also to individuals prior to plan selection, to aid informed plan choice and help women and couples obtain the contraceptive method that will work best for them at no cost sharing, as guaranteed by the ACA.
These regulations also provide an opportunity for CMS to incorporate and clarify the administration’s February 2013 guidance on the preventive services provision more broadly. That guidance laid out in detail how issuers must comply with this provision. However, in the time since, there have been reports of persistent problems with how plans are interpreting the provision. CMS can address this by making clear that the following practices are violations of the law:

- **Excluding coverage of specific contraceptive methods, such as the patch or the ring.** These methods are categorized by the FDA as independent methods, but some plans have incorrectly argued that certain generic pills are medically equivalent as justification for not covering these independent methods without cost-sharing.

- **Excluding coverage of related services intrinsic to the provision of certain contraceptive methods, such as the IUD and implant.** The guidance makes clear, as should CMS, that plans must cover device removal, follow-up, management of side effects and counseling for continued adherence. Additionally, CMS should clarify that these are just examples of associated care, and plans must cover without cost sharing the full range of services associated with contraceptive methods, such as necessary testing and anesthesia.

- **Imposing inappropriate medical management techniques.** CMS should clarify that states and health plans may not interfere with enrollees’ guarantee of family planning coverage through such practices as prior authorization, step therapy, inappropriate quantity limits, or any other requirements that lack a clinical evidence base.

- **Requiring enrollees to use either mail-order programs or retail pharmacies.** CMS should clarify that the preventive services provision guarantees coverage without cost-sharing through all types of vendors, including both mail-order programs and brick-and-mortar pharmacies.

In addition, CMS should incorporate into regulation the requirement from the February 2013 guidance that plans must allow health care providers to waive formulary restrictions on coverage of contraceptives and other preventive drugs, and should require plans to clearly communicate that process to enrollees and providers.

**Special Enrollment Periods**

Pregnancy is a life event that often requires women to seek new, specialized health care and providers. Although a woman may have coverage at the time she becomes pregnant, not all health plans have equally robust benefits for prenatal and maternity care, and provider networks—including participating hospitals—vary among plans. A newly pregnant woman may feel the need to seek different coverage that will meet her changing health care needs, commonly including access to nearby obstetricians and gynecologists with whom she feels comfortable and a hospital where she would like to deliver. As such, CMS should establish pregnancy as a qualifying life event that triggers a special enrollment period during which time a woman can select or change health plans.
We hope you find these comments useful as you move to finalize this guidance and plan for future rulemaking. If you need additional information about the issues raised in this letter, please feel free to contact Kinsey Hasstedt in the Institute’s Washington office. She may be reached either by phone at 202-296-4012 or by email at khasstedt@guttmacher.org.

Thank you for your consideration.

Sincerely yours,

Rachel Benson Gold
Vice President for Public Policy