January 12, 2015

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

RE: Health Benefit Plan Network Access and Adequacy Model Act

Dear Sir or Madam:

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to comment on the National Association of Insurance Commissioners’ (NAIC) Health Benefit Plan Network Access and Adequacy Model Act. NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS’ 125 chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.8 million individuals, including 175,000 pharmacists. They fill over 2.7 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 800 supplier partners and nearly 40 international members representing 13 countries.

Section 3-Definitions

NACDS supports NAIC’s inclusion of pharmacies within the definition of the term “health care provider.” We believe that it is important that states and the federal government strengthen network adequacy standards within the pharmacy sector, as well as the medical sector. Including pharmacies as providers within this model language helps to achieve this goal. For consistency purposes, we encourage NAIC to also define the term “health care professional” to include a pharmacist, as well as a physician.

Section 5 and Section 6-Network Adequacy, Network Sufficiency and Health Carrier Selection Standards

Section 5.A of NAIC’s model act anticipates network plan adequacy standards that focus on sufficient numbers and types of providers and patient access to health care services without unreasonable delay. NACDS supports this standard. However, we encourage NAIC to layer this sufficiency and unreasonable delay standard on top of any willing provider (AWP) standard. In other words, we believe that the model act should provide, at a minimum, for network access to any willing provider who is willing to accept the terms and conditions of the health carrier’s contract. Assuming a health carrier meets those requirements, we support also requiring the carrier to ensure that the sufficiency and unreasonable delay standards contained in Section 5.A and B are also met.
For example, in certain health care programs, such as the fee-for-service Medicaid program, there are open provider networks in which any neighborhood pharmacy is able to participate as a provider as long as they adhere to the requirements of the Medicaid program. These open networks maintain continuity of care and allow Medicaid beneficiaries to receive pharmacy services at conveniently located community pharmacies. However, managed care organizations (MCOs), oftentimes through a pharmacy benefit manager (PBM), establish restrictive networks, and thus limit an enrollee’s access to readily available healthcare services. NACDS believes that such restrictions are harmful to patient choice and access to care. Accordingly, we believe that patients should be allowed the freedom to select a health care provider that best fits their personal health needs and provides the most accessible care through open networks.

With respect to ensuring adequate pharmacy access, we believe the model act should follow the same pharmacy access standards as required for the Medicaid fee-for-service program by allowing any willing pharmacy the opportunity to participate in a MCO’s or PBM’s pharmacy network. Making this change would require altering the language in Section 5.A and B regarding network adequacy and sufficiency, and Section 6.F regarding provider selection standards.

Turning to the model act language on network sufficiency, NACDS supports the sufficiency criteria outlined in Section 5.B. However, to ensure that patients have access to a sufficient number of locations from which to get their medications, we suggest NAIC provide more detailed criteria for network sufficiency and consider the following language to be included in Section 5.B. The proposed language would prevent PBMs and MCOs from imposing unnecessary burdens and unworkable network requirements on pharmacies. It would decrease the likelihood that patients would face access barriers and may not be able to get their prescriptions when they need them, thus helping to prevent non-adherence and associated health complications and costs:

(A) A MCO, or contracted PBM, shall not mandate that a covered individual use a specific retail pharmacy, mail order pharmacy, specialty pharmacy or other pharmacy or entity if the MCO or PBM has an ownership interest in such pharmacy, practice site, or entity or that the pharmacy, practice site or entity has ownership interest in the MCO or PBM. Nor can the MCO or PBM provide incentives to beneficiaries to encourage the use of a specific pharmacy if only applicable to a MCO or PBM pharmacy.

(B) A MCO or PBM may not require that a pharmacist or retail pharmacy participate in a network managed by such MCO or PBM as a condition for the retail pharmacy to participate in another network managed by the same MCO or PBM.

(C) A MCO or PBM may not exclude an otherwise qualified pharmacist or retail pharmacy from participation in a particular network provided that the pharmacist or pharmacy accepts the terms, conditions, and reimbursement rates of the MCO or PBM, and meets all applicable federal and state licensure
and permit requirements and has not been excluded from participation in any Federal or State program.

(D) A MCO or PBM may not automatically enroll or disenroll a retail pharmacy in a contract or modify an existing agreement without written agreement of the pharmacist or retail pharmacy.

(E) If a MCO or PBM establishes a discount card network, the MCO or PBM shall not require participation in the discount card network by a pharmacy in exchange for participation in the broader retail network. The MCO or PBM shall allow a pharmacy to opt-out of the discount card network and choose to only participate in the MCO’s or PBM’s funded retail network.

(F) A MCO or PBM must have a contracted pharmacy network consisting of retail pharmacies sufficient to ensure that the following requirements are satisfied:

1. At least 90 percent of health plan beneficiaries, on average, in urban areas served by the MCO or PBM live within 2 miles of a network pharmacy that is a retail pharmacy.

2. At least 90 percent of health plan beneficiaries, on average, in suburban areas served by the MCO or PBM live within 5 miles of a network pharmacy that is a retail pharmacy.

3. At least 70 percent of health plan beneficiaries, on average, in rural areas served by the MCO or PBM live within 15 miles of a network pharmacy that is a retail pharmacy.

These suggested provisions should help ensure that patients have continued access to retail pharmacies to obtain their prescription drugs.

Section 6-Requirements for Health Carriers

Focusing on the model act requirements for health carriers, as noted above, NACDS requests that NAIC modify Section 6.F of the model act – regarding provider selection standards – to conform with an AWP standard. Nonetheless, NACDS supports NAIC’s addition of language to Section 6.T that would require a health carrier to timely notify a participating provider of contract provisions at the time that the contract is executed and at the time of any material changes to the contract. In the context of contracting with MCOs and PBMs, at times, NACDS members have encountered MCOs and PBMs making material changes to payment terms within a contract without notifying the pharmacy. We believe that improved transparency is needed in this regard.

1 These are the access standards used in the Medicare Part D and TRICARE programs.
Section 8-Provider Directories

NACDS applauds NAIC for proposing to require health carriers to publish up-to-date online provider directories with search functions and monthly updates. We agree with efforts to strengthen provider directory requirements and we support transparency and ease of access for beneficiaries seeking to find in-network providers.

Section 12-Enforcement

NACDS appreciates some of the enforcement provisions that the model act contemplates to be used against health carriers who do not comply with the act. However, we are concerned about NAIC’s proposal that a state insurance commissioner shall not arbitrate, mediate or settle disputes regarding a health carrier’s decision to exclude a provider from a network plan. More specifically, NACDS is concerned that an aggrieved provider may have no recourse against a health carrier who wrongfully excludes that provider from a plan network. Accordingly, we request that NAIC modify the proposed language to allow commissioners to arbitrate, mediate or settle such disputes, or alternatively to draft language to provide for an alternative remedy for aggrieved providers.

Conclusion

We appreciate the opportunity to share our comments and concerns on NAIC’s Health Benefit Plan Network Access and Adequacy Model Act. We thank you in advance for your consideration of our perspectives.

Sincerely,

Christopher R. Smith, JD, LLM
Director of Federal Public Policy