COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

December 10, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt:

The President promised the American people that if you like your health insurance plan, you can keep it under his health care law. He promised that if you like your doctor, you can keep your doctor. We now know this not to be the case. Individuals who have purchased health insurance plans on an exchange are too often finding narrow networks and lack of access to specialty providers. We are requesting information about the level of transparency with which the Centers for Medicare and Medicaid Services (CMS) is carrying out the new network regulations created as a result of the President's health care law and how those actions affect state regulation as well as consumers' ability to find the plans that best work for them and their families.

All across the United States, Americans are facing limited health plan and provider choices. Recently, UnitedHealth, the nation's largest insurer, revealed that they were facing major financial losses in their health insurance exchange products and are contemplating exiting the exchanges entirely in 2017.[1] This could mean tremendous disruptions for the over half a million people insured through UnitedHealth. Other insurers are expressing concerns for their exchange products and are dropping coverage options and/or narrowing provider networks in the areas they cover as well. For example, one of Texas' largest insurers announced they would discontinue their most popular PPO from the federal exchange. This would disrupt the coverage of thousands of individuals as they potentially lose access to their doctors, trusted providers and specialists.[2]

Collectively, insurers have lost $2.5 billion on ACA-compliant plans in the individual market in 2014, with many expecting to lose more in 2015.[3] More than half of the health insurance CO-OPs created by the law have closed, leaving behind not only their own failures, but a wake of

---

[1] Anna Wilde Mathews, *UnitedHealth Raises Doubts About Its Participation in Affordable Care Act*, WALL STREET JOURNAL (Nov 19, 2015).

[2] Jim Landers, *BlueCross BlueShield of Texas to drop individual PPO plans in 2016*, DALLAS MORNING NEWS (July 24, 2015).

[3] Anna Wilde Mathews, *Health Insurers Struggle to Profit from ACA Plans*, WALL STREET JOURNAL (Nov. 1, 2015).

problems for other insurers in the same market as a result of the CO-OPs' mispricing.[4] Under these circumstances, it is not surprising that insurers are re-evaluating their future participation in the exchanges.

We know the benefit mandates, new taxes and fees and other regulatory requirements contained in the President's health care law continue to place upward pressure on premiums and are restraining health plans' efforts to develop affordable products for consumers with varied needs in the marketplace. Ultimately, we believe the burdensome regulations placed on insurers have contributed to the high cost and the lack of access to certain specialty healthcare services.

This is further exacerbated by the continued problems related to the transparency of qualified health plan (QHP) networks. Notwithstanding regulatory actions by the states, HHS continues to impose their own requirements on provider networks for plans sold on the federal exchanges, often with very limited information on what these standards are. Additionally, information available to individuals seeking coverage on provider networks on a health insurance exchange is limited, sometimes out of date or incorrect. Access to clear, accurate, and understandable information on federal standards related to QHP networks remains a challenge. Without this information, it is impossible for consumers to identify plans that best meet their specific health care needs.

In order to better understand the CMS's actions on this issue, please provide answers to the following questions, by December 24, 2015:

1. CMS has stated an intent to impose their own network adequacy requirements on QHP's in FFM states where state network adequacy requirements don't meet CMS's standards. Before the takeover of the President's health care law, insurance regulation has historically been done by the states. How will CMS determine whether a state will be overruled by CMS's network adequacy rules?
2. What specific rules are used to determine whether a QHP has met CMS's network adequacy requirement?
3. What factors does CMS consider when determining a plan provides a "sufficient choice of providers"?
4. How does CMS identify deficiencies in these requirements? What is the process for resolving such deficiencies?

[4] Tom Howell Jr., *Obamacare co-op flops have many running for coverage*, WASHINGTON TIMES (Nov. 15, 2015).

Thank you for your attention to this matter. If you have any questions, please contact Committee staff at 202-225-5522. I look forward to your timely response.

Sincerely,

Kevin Brady
Chairman

Pat Tiberi
Chairman
Subcommittee on Health

Peter J. Roskam
Chairman
Subcommittee on Oversight

cc: The Honorable Sander Levin, Ranking Member
The Honorable Jim McDermott, Ranking Member, Subcommittee on Health
The Honorable John Lewis, Ranking Member, Subcommittee on Oversight