

November 16, 2014

The Honorable Sandy Praeger
Commissioner
Kansas Department of Insurance
420 SW 9th Street
Topeka, Kansas 66612-1678

The Honorable Theodore K. Nickel
Commissioner
Office of the Commissioner of Insurance
State of Wisconsin
125 South Webster Street
Madison, Wisconsin 53707-7873

Dear Commissioners Praeger and Nickel:

The undersigned organizations representing hospitals, physicians, and other health care providers serving both children and adults, as well as health care consumers and other stakeholders, wish to thank you for the opportunity to provide the perspective of our members on the development of meaningful standards for network adequacy. As the National Association of Insurance Commissioners (NAIC) continues the process to revise its 1996 Managed Care Plan Network Adequacy Act (Model Act #74), we have joined together to make the following recommendations. We believe that these issues must be addressed in the final Model Act:

- Provider networks must include a full range of primary, specialty and subspecialty providers for children and adults to ensure that consumers have access to all covered services, at every level of complexity, without administrative or cost barriers;
- Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards;
- Appeals processes must be fair, timely, transparent and rarely needed. Appeals and other out-of-network arrangements must not be used as an alternative to an adequate network for all covered services;
- The use of tiered provider networks and formularies must be regulated to ensure that consumers of all ages have access to all covered services, including specialty services, without additional cost sharing or administrative burdens;
- Insurers must be unequivocally transparent in provider selection standards; and
- Provider directories must be accurate, up-to-date and easily accessible.

We recognize that there already is broad regulator support for these concepts, and we appreciate that the NAIC has been deliberative in hearing from all interested parties. By adopting provisions consistent with the principles outlined in this letter, we believe lawmakers and regulators can adapt the Model Act to establish reasonable, meaningful standards, while still allowing for market flexibility and choice.

1. Provider networks must include a full range of primary, specialty and subspecialty providers for all covered services for children and adults.

Health plans must be able to demonstrate that their enrollees have access to a full range of pediatric and adult providers for all covered services, from primary care to specialty and subspecialty providers for complex medical needs. To ensure that plans fulfill their obligations to cover their beneficiaries and are not discriminating based on health status, the Model Act must include provisions that:

- Require all health plan networks to include providers that deliver high-quality wellness and prevention care, care for episodic illness, a full spectrum of post-acute care services, management of chronic conditions, and advance illness care for both children and adults. Inadequate and limited networks that do not include this range of providers may result in care delays with poor medical outcomes that ultimately cost insurers and consumers more.
- Provider networks must be evaluated for their capacity to address the needs of covered persons who may face barriers to access to care, including but not limited to children and adults with serious, complex or chronic medical conditions; and individuals with limited English proficiency and illiteracy, diverse cultural and ethnic backgrounds, and physical and mental disabilities.
- An emphasis must be placed on ensuring that consumers have access to care provided by all types of essential community providers, a medical home that can coordinate care, behavioral health services, and hospital-based care to meet specific needs, including but not limited to academic medical centers, children's hospitals, oncology centers, and transplant centers.
- Children and adults with complex and chronic medical needs must be provided access to a choice of in-network specialists and subspecialists, as well as appropriate community and specialty facilities, for the treatment of their medical and behavioral health conditions. As detailed elsewhere in this letter, reliance on appeals, grievance or other processes to account for access to specialty care reflects an inadequate network.

2. Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards

Determinations of network adequacy must be the responsibility of regulators, utilizing strong quantitative and objective measures that take into consideration geographic challenges and the entire range of consumers' health care needs. Quantitative network measures will require state regulators to more effectively evaluate, monitor, and enforce insurers' networks to protect consumers, and eliminate dependence on insurer self-attestation or third-party certification regarding network adequacy.

We urge the NAIC to incorporate into the Model Act the types of quantitative measurements to be used, but allow regulators to adapt specific thresholds reasonable for their state. For example, the use of commonly used distance standards would not be an appropriate measure of a network's adequacy for children in need of the tertiary and quaternary specialty care provided by a children's hospital. In fact, if those standards are the sole determinant of a network's adequacy, almost half of all children would not have access to the specialty care provided through a children's hospital given the regional nature of that care.¹

Therefore, it is imperative that the Model Act include provisions that call for the use of a broad set of quantitative measures, as no individual measurement is likely to ensure access, and in fact, if used alone, may provide a false assessment of adequacy.

Among the quantitative measures that should be delineated in the Model Act are the following:

- Maximum travel time and distance, with appropriate adjustments for geographic differences and for the regionalization of specialty care to assure access to all covered services;
- Maximum appointment wait times;
- Provider capacity and admitting of new patients;
- Minimum providers available to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, physical and mental disabilities, and children and adults with complex medical conditions;
- Provider hours and availability;
- Availability of technological, diagnostic and ancillary services; and
- Patient feedback, as well as issuer documentation of, network access, particularly for children and adults with complex and chronic conditions.

It is important to note that quantitative standards do not diminish the need for regulators to individually assess networks that may employ unique techniques to ensure access to care that

¹ Analysis by the Children's Hospital Association, November 2014.

may fall outside the established objective requirements. For instance, as noted above, there may not be specific specialty care available within the required time and distance standards. However, if the insurer has arranged for access to that specialized care outside the geographic region, the regulator should still consider approval of the network.

We also wish to highlight the importance of the use of quality measurement, as well as patient feedback through regular consumer surveys and consumer complaints, in the evaluation of network adequacy. Finally, ensuring access to care and establishing consumer protections starts with having standards that are applied fairly and consistently on all insurers.

3. Appeals processes must be fair, timely, transparent and rarely needed

The Model Act must make clear that out-of-network arrangements and procedures are not an acceptable alternative to plans having an adequate network. Our organizations are extremely concerned about a reliance on appeals processes and other administrative procedures as a remedy for networks that are so narrow that one must go out-of-network to access covered services. Furthermore, we believe that the best way to ensure patients' access to care is to establish strong network adequacy requirements that meet the needs of both children and adults so that appeals processes are rarely, if ever, needed. A reliance on appeals processes to resolve network inadequacies does not reduce health care costs; instead, they leave consumers at risk of delayed and fragmented care and providers with additional administrative costs, all of which increase the overall costs of care.

Therefore, we urge the NAIC to consider and adopt the following requirements:

- All networks should meet or exceed network adequacy requirements and provide consumers access to all covered services.
- When out-of-network care is received because there is no provider in-network capable of providing a covered service, cost-sharing and other plan requirements for the consumer should be the same as if the provider was contracted and in-network. In addition, the insurer must take immediate steps to remedy the gaps in the network.
- In instances when an in-network provider is not available, plans should demonstrate that they maintain an adequate and timely approval process for out-of-network services, utilize appropriate clinical standards in evaluating requests, and have an appeals process for denied services.

Finally, we recognize the need for insurers to have the requisite flexibility to incent physicians, hospitals and other health care providers and facilities to contract in good faith. We are concerned, however, that permitting insurers to pay non-contracted providers deeply discounted, non-negotiated rates to remedy inadequate networks will not protect consumers. In fact, this practice may have the unintended consequence of encouraging insurers to create inadequate networks in the first place. Therefore, when there is an inadequate network, we believe that payers should be required to reimburse providers the reasonable and customary value for out-of-

network services. This both protects the patient and helps ensure a level playing field during contract negotiations.

4. The use of tiered and narrow provider networks and formularies must be regulated

Specific patient protections must be included in the Model Act for networks that are tiered or are limited in scope and number of providers in order to prevent unfair discrimination based on health status. The selection criteria utilized by health carriers for participation in these more restricted or narrow networks must consider the quality of the health services provided and the ability of the in-network providers to deliver all necessary covered services, including specialty and subspecialty care. In particular, narrow and tiered networks must not be designed solely on the basis of cost and must not impede the provision of timely and high quality care, especially for children and adults with complex medical conditions.

As you know, in a tiered network design, providers are placed into tiers and consumer cost-sharing progressively increases when the selected provider is in a higher tier. The increases in cost-sharing between network tiers are often dramatic and can have a negative impact on patients. Similarly, if a network plan's drug formulary is constructed in such a way as to place needed specialty medications and services in the highest tiers, consumers will suffer a large financial burden and may delay the purchase of needed drugs and follow-up care. As a result, tiered formularies can result in reduced medication adherence, worsening health conditions, and higher costs.

To address these concerns, we urge inclusion of the following requirements in the Model Act to ensure that tiering and other types of network and formulary designs do not impede access to timely and quality medical care:

- Network adequacy standards should apply to the lowest cost-sharing tier of any tiered network. That tier must include the full range of specialty care providers for all covered services, including children's hospitals, cancer hospitals, and a range of specialists and subspecialists. The widely understood objective of cost-sharing is to encourage certain consumer decisions. But if there are not enough providers – both primary and specialty care for children and adults – available in the lowest cost-sharing tier, the additional cost-sharing associated with providers in a higher tier is simply an unfair and costly consumer penalty.
- There must be clear consumer information regarding provider networks and formularies that are tiered, including information about cost-sharing responsibilities associated with each tier, and appeals processes. Consumer information is absolutely critical to informed decision-making and out-of-pocket expenses that may be incurred as a result of those decisions. This consumer information must be provided during plan selection to enable individuals and families with specific health care needs to choose the most appropriate plan to meet those needs. There must also be stringent oversight and intervention by regulators when tiers are designed in such a manner as to effectively deny consumers the

value of the premium they have paid and coverage for all benefits promised under the plan.

- A tiered or narrow network may also include integrated/coordinated delivery systems, modeled after accountable care organizations, made up of providers and facilities that coordinate primary and specialty care. The use of an integrated delivery system as part of a tiered network does not relieve the health carrier from its responsibility to provide access to medically necessary covered services not otherwise available from the integrated delivery system. That care may include specialty care for children and adults who have complex medical conditions, such as pediatric specialty services, specialized cancer treatment, tertiary and quaternary care, as well as psychiatric and substance abuse treatment.
- The Model Act must protect consumers from higher cost-sharing when their current provider is switched from one tier to another. This should be recognized as a continuity of care issue, given that movement of a provider among tiers can have a significant impact on the important patient-provider relationship and the patient's ability to continue with ongoing care.

5. Insurers must be transparent in the design of their provider networks

It is critical that consumers have clear information regarding the design of their plan's provider network. Therefore, the Model Act must include provisions that require transparency in network design and oversight mechanisms to ensure compliance.

First, full transparency of issuers' provider selection standards is critical, given the shift toward narrow and tiered networks, many of which seem to be designed on the basis of cost, rather than quality. The tiering of certain specialty providers into higher cost tiers or the exclusion of those providers from a network is problematic because it could place unanticipated costs onto patients enrolled in the plan or deter patients with serious medical needs from that plan or product. Not only do those plans run the risk of being insufficient for children and adults with specialized health care needs, but they may also violate non-discrimination protections.

Second, issuers may identify networks that exclude specialty providers as "high-value" or "high-performing," and, thus, imply that provider quality has been considered in the development of the network. In the event that quality is a factor that is used in the design of a network, consumers and providers should have information regarding the quality measures that were used. By the same token, if quality measures have not been used to create the network, it is critical that consumers, providers and regulators are made aware of the basic methods that were used to create the network, which may be centered on lower-cost providers.

6. Provider directories must be accurate and up-to-date

We agree with the NAIC network adequacy task force that consumers must have access to robust, up-to-date provider directories to enable them to determine which providers are in-network when they purchase their plans, and, in the event their medical needs change, when they need new providers. Furthermore, providers need accurate information from health plans to allow for in-network referrals when further, specialized treatment is warranted.

Provider directories should provide as much detail as possible about network providers including, but not limited to:

- Name, address, county, office telephone number, and Web site address or other link to more detailed individual provider information, if available;
- Hours of operation;
- If the network is tiered, a conspicuous disclaimer indicating which tier the provider is in, how that provider tier impacts consumer's financial or other obligations, and any appeals or prior authorizations processes;
- Listings of hospitals by type (e.g. general acute care, children's, cancer, orthopedic, rehab);
- Specialty and/or subspecialty information;
- Whether the provider is accepting new patients;
- Names and locations of the hospital(s) where the physician or other provider has medical staff privileges and whether those hospitals are part of the provider network;
- Indication of whether the physician may be selected as a primary care physician; and
- Generally accepted and appropriate quality measures, if used by the insurer.

Updates to online directories should be made in a timely fashion. Moreover, it is critically important that regulators monitor the accuracy of provider directories on an ongoing basis and especially at open enrollment. The impact of inaccurate provider directories on consumers can be devastating, especially on those consumers who need to carefully examine networks for specific subspecialists, cancer centers, children's hospitals, etc.

Finally, we want to emphasize that transparency in directories and up-to-date information on providers is not a substitute for a robust network that allows access to all covered services for both children and adults. Rather, transparent and accurate consumer information should be used as a means to educate consumers about the full scope and limits of a provider network so they have meaningful access to the care they need when they need it.

Conclusion

Our organizations are committed to working with you to strengthen the NAIC Model Act #74 to ensure that all consumers have timely access to covered services, regardless of the complexity of their needs. We appreciate your continued attention to the priorities of our organizations and the consumers we serve.

Sincerely,

Alliance of Dedicated Cancer Centers
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pediatrics
American Association for Marriage and Family Therapy
American Association of Neurological Surgeons
American College of Emergency Physicians
American College of Phlebology
American College of Physicians
American College of Radiology
American College of Rheumatology
American Health Care Association/National Center for Assisted Living
American Group Psychotherapy Association
American Medical Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Optometric Association
American Osteopathic Association
American Psychiatric Association
American Psychological Association
American Society for Dermatologic Surgery Association
American Society for Surgery of the Hand
American Society for Reproductive Medicine
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Echocardiography
American Society of Interventional Pain Physicians
American Society of Neuroradiology
American Society of Transplant Surgeons

American Speech-Language-Hearing Association
American Telemedicine Association
American Therapeutic Recreation Association
American Thoracic Society
American Urological Association
Association for Ambulatory Behavioral Healthcare
Cancer Support Community
Children and Adults with Attention Deficit/Hyperactivity Disorders
Children's Hospital Association
Children Now
Children's Partnership
College of American Pathologists
Colorado Medical Society
Congress of Neurological Surgeons
Connecticut State Medical Society
Family Voices
First Focus
Easter Seals
Epilepsy Foundation
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Kidney Care Council
Leukemia & Lymphoma Society
Maine Medical Association
Massachusetts Medical Society
MedCHI, The Maryland State Medical Society
Medical Association of Georgia
Medical Association of the State of Alabama
Medical Group Management Association
Medical Society of Delaware
Medical Society of the District of Columbia
Medical Society of New Jersey
Medical Society of the State of New York
Medical Society of Virginia
Mental Health America
Michigan State Medical Society
Minnesota Medical Association
Mississippi Ambulatory Surgery Center Association
Mississippi State Medical Association
Missouri State Medical Association

Montana Medical Association
National Alliance to Advance Adolescent Health
National Association of Medical Examiners
National Alliance on Mental Illness
National Association of School Nurses
National Association of State Mental Health Program Directors
National Council for Behavioral Health
National Marrow Donor Program-Be The Match
Nebraska Medical Association
Nevada State Medical Association
New Mexico Medical Society
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Parity Implementation Coalition
Pediatric Congenital Heart Association
Pennsylvania Medical Society
Physicians Advocacy Institute, Inc.
Rhode Island Medical Society
Society for Cardiovascular Angiography and Interventions
Society of Critical Care Medicine
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
United Cerebral Palsy
United Spinal Association
Vermont Medical Society
Washington State Medical Association
Wisconsin Medical Society

cc: Members of the NAIC Health Insurance and Managed Care (B) Committee
Members of the NAIC Regulatory Framework (B) Task Force
Members of the NAIC Network Adequacy Model Review Subgroup
Jolie Matthews, Senior Health Policy Advisor and Counsel, NAIC