October 26, 2015

The Honorable Roger A. Sevigny
Commissioner
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

The Honorable Mike Kreidler
Commissioner
Office of the Commissioner of Insurance
Insurance Building, Capitol Campus
Olympia, WA 98504

**RE: Managed Care Plan Network Adequacy Model Act**

Dear Commissioners Sevigny, Kreidler, and Members of the Health Insurance and Managed Care (B) Committee:

The undersigned organizations representing health care consumers, physicians, hospitals and other health care providers write to request your consideration of our shared priorities for incorporation into the final National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act (Model Act).

Our organizations strongly support many of the important new provisions in the current draft and appreciate the work of the NAIC's Network Adequacy Model Review (B) Subgroup to craft the bill in an inclusive manner. However, we believe that further attention to the issues outlined below are essential to ensure that the Model Act fulfills the pressing needs of children and adults to access all covered health care services. Specifically, we respectfully urge the B Committee to focus on three areas:

- **Active approval of networks prior to products going to market.**
- **The use of quantitative measures to determine network adequacy.**
- **Regulation of tiered networks to prevent discriminatory network design.**

By revising the draft Model Act to incorporate these key patient protections, which we explain in more detail below, we believe state legislatures and Insurance Commissioners (Commissioners) will be better equipped to establish reasonable, meaningful standards for network adequacy, while still allowing for market flexibility and choice.

1. **The Model Act should require active approval of networks prior to products going to market.**

The current Model Act provides states the option of either requiring Commissioner-approval of network access plans prior to going to market or allowing Commissioner-review of network

plans after the plans already have been marketed and sold to consumers. Our organizations strongly recommend that the Model Act be revised to require prior approval of access plans by the Commissioner.

By providing these two options, the NAIC is suggesting to legislatures that it is acceptable for issuers to sell consumers a product with a network that has never been determined to be adequate. We disagree. It is critical, especially in this changing health care environment with rapidly evolving network designs, that regulators actively seek to identify and address network adequacy problems within a plan's network ***before*** the product is ever sold to and relied upon by patients. At a time when networks are narrowing and consumers are facing greater out-of-pocket costs, consumers need a basic level of assurance that the plan they are buying has the ability to deliver promised benefits. A front-end evaluation will prevent consumers from purchasing an inadequate product and experiencing access problems or unexpected out-of-pocket costs at the time care is needed.

Specifically, we suggest that the final Model Act require health plans to file an access plan with the Commissioner for approval ***prior to*** allowing the network product to be offered to consumers. We also suggest that the Model Act require Commissioner-approval of a revised access plan prior to implementing any material changes to an existing network.

We appreciate the concerns expressed in the Subgroup about the challenges some states may have to accomplish this, such as limited resources. But without prior approval, consumers are put in a precarious position to rely largely on issuers' promises of adequacy and the hope that deficiencies will be corrected after the fact, often after a consumer is locked into a plan and unable to switch plans until the next open enrollment period. The history of consumer problems with network access show that this approach is not sufficient. We believe that the Model Act must provide the highest level of protection for consumers.

2. **The Model Act should require the use of quantitative measures to determine network adequacy.**

The use of a set of quantitative measures, to be established through required state rulemaking, allows state regulators to effectively evaluate, monitor, and enforce insurers' networks using standards consistent across carriers. The draft Model Act outlines several types of quantitative measurements that may be used, while allowing regulators to adopt specific thresholds reasonable for their state. But unfortunately, again, the current draft Model Act provides these measures as an option for states, rather than a requirement.

Our organizations strongly believe that the establishment of a clear set of numeric quantitative standards are necessary to assure network adequacy. Without measurable criteria, insurers within a state may have different interpretations of what is sufficient, resulting in an uneven playing field since the strength of each issuers' network could vary greatly but still be considered adequate. Additionally, without clear quantitative metrics, Commissioners may find it harder to enforce their interpretation of sufficiency, as their interpretation may be challenged by different stakeholders. Such a situation may also leave consumers without clearly enforceable rights, as

consumers will be hard pressed to prove that a given network is inadequate even if it is not meeting their needs for providing covered benefits.

The use of quantitative standards is already required in many insurance markets. For example, the Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage plans to meet quantitative standards and recently proposed that states must adopt quantitative standards for Medicaid managed care plans. Many states also use quantitative standards in their HMO and/or PPO markets.[1] Without direction in the Model Act to states to set their own quantitative standards that are appropriate for their regulated networks and covered populations, CMS is likely to consider developing its own framework for quantitative standards for qualified health plans.

We ask that you clarify in the final Model Act that Commissioners should, through required rulemaking, adopt a set of quantitative measures appropriate for their state to assure access to all covered services by participating providers with the requisite training and expertise to provide that care. These standards will establish a floor that network plans must meet in order to be determined to be sufficient – and provide essential consumer confidence that the network plans have met those standards.

### 3. Tiered networks should be regulated under the Model Act, to prevent discriminatory network design and ensure adequacy.

Our organizations are very concerned that tiered networks – networks that assign different levels of consumer cost-sharing to different tiers of providers – are being designed in a discriminatory fashion and hindering access to covered services. For example, providers that may subspecialize and care for patients with more complex needs may be placed into higher cost-sharing tiers, forcing patients who need to access these providers to pay significantly more out-of-pocket even though such care is a covered benefit. In addition, the lowest cost-sharing tier may not include sufficient numbers or types of providers to offer consumers access to affordable covered services.

We are pleased to see increased attention paid to providing greater transparency with respect to tiered networks in the draft Model Act. However, we collectively believe stronger model language is needed to prevent discriminatory or inadequate plan designs that would not assure that all covered benefits are available at the expected cost-sharing levels. **Specifically, we ask that you apply all network adequacy standards to the lowest cost-sharing tier of any tiered network.** That tier must include a full range of providers for all covered services. We know that

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[1] See Justin Giovannelli, Kevin W. Lucia, and Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks* (New York: Commonwealth Fund, May 2015), available online at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf; Claire McAndrew, *Standards for Health Insurance Provider Networks: Examples from the States* (Washington: Families USA, November 2014), available online at: http://familiesusa.org/product/standards-health-insurance-provider-networks-examples-states.

some states have already adopted requirements to protect consumers from possible discrimination in the design of tiered networks.

The widely understood objective of cost-sharing is to influence certain consumer decisions. However, if there are not appropriate providers – primary, specialty, and subspecialty 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 a discriminatory and costly consumer toll. Such tiering denies consumers the value of the premium they have paid, and likely the ability to access promised health care services.

Thank you for your consideration of our priorities. We hope that the B Committee will expeditiously adopt these recommended changes to the Model Act before approving it and sending it to the full NAIC for adoption. We look forward to working with you to strengthen the final Model Act.

Sincerely,

## National Organizations

AARP
ADAP Advocacy Association (aaa+)
Adult Congenital Heart Association
Advocacy Council of the American College of Allergy, Asthma and Immunology
Alpha-1 Foundation
Alliance of Dedicated Cancer Centers
American Academy of Allergy, Asthma and Immunology
American Academy of Child & Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of HIV Medicine
American Academy of Neurology
American Academy of Otolaryngology—Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Association on Health and Disability
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Association on Health and Disability
American Cancer Society Cancer Action Network
American College of Allergy, Asthma and Immunology
American College of Emergency Physicians
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Surgeons
American College of Radiology

American College of Rheumatology
American Heart Association/American Stroke Association
American Kidney Fund
American Medical Association
American Osteopathic Association
American Physical Therapy Association
American Psychiatric Association
American Society for Dermatologic Surgery Association
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Dermatopathology
American Society of Hematology
American Society of Plastic Surgeons
American Society for Surgery of the Hand
American Society of Retina Specialists
American Thoracic Society
American Urological Association
The Arc of the United States
Autism Speaks
Brain Injury Association of America
Children's Hospital Association
College of American Pathologists
Community Access National Network (CANN)
Community Catalyst
Congress of Neurological Surgeons
Consumers Union
COPD Foundation
Dab the AIDS Bear Project
Dialysis Patient Citizens
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation
Families USA
Family Voices
First Focus
HIV Medicine Association
Heartland Alliance for Human Needs and Human Rights
International Society for the Advancement of Spine Surgery
Lakeshore Foundation
The Leukemia & Lymphoma Society
Lupus and Allied Diseases Association, Inc.
Medical Group Management Association
Medicare Rights Center
National Health Council
National Health Law Program

National Hemophilia Foundation
National Multiple Sclerosis Society
National Partnership for Women & Families
National Stroke Association
North American Neuromodulation Society
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition
Renal Physicians Association
Parkinson's Action Network
Sargent Shriver National Center on Poverty Law
Susan G. Komen
UCP
United Spinal Association
30 for 30 Campaign

## State Organizations

AIDS Alabama
Medical Association of the State of Alabama
Arizona Chapter, American Academy of Pediatrics
Arizona Medical Association
California Lesbian, Gay, Bisexual, and Transgender Health and Human Services Network
California Medical Association
San Francisco AIDS Foundation
Colorado Chapter, American Academy of Pediatrics
Colorado Consumer Health Initiative
Colorado Medical Society
Medical Society of the District of Columbia
Medical Society of Delaware
Florida Alliance for Retired Americans
Florida CHAIN
Florida Medical Association
The League of Women Voters of Florida
Georgians for a Healthy Future
Georgia Watch
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Health Reform Resource Project
Kentucky Equal Justice Center
Kentucky Mental Health Coalition
Maine Consumers for Affordable Health Care
Maine Medical Association
Maryland Citizens' Health Initiative
Maryland Women's Coalition for Health Care Reform

MedChi, The Maryland State Medical Society
Mental Health Association of Maryland
NAMI (National Alliance on Mental Illness) Maryland
Health Care For All Massachusetts
Massachusetts Medical Society
Michigan League for Public Policy
Michigan State Medical Society
Minnesota Chapter, American Academy of Pediatrics
Minnesota Medical Association
TakeAction Minnesota
Missouri Health Advocacy Alliance
Missouri State Medical Association
Montana Medical Association
Nevada Section of the American College of Obstetricians and Gynecologists
New Hampshire Medical Society
New Hampshire Pediatric Society
Medical Society of New Jersey
New Mexico Medical Society
Center for Independence of the Disabled (NY)
Community Service Society of New York
Health Care for All New York (HCFANY)
Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage
District II New York State, American Academy of Pediatrics
New York Chapter 1 of the American Academy of Pediatrics
New York Chapter 2 of the American Academy of Pediatrics
New York Chapter 3 of the American Academy of Pediatrics
North Carolina Community Health Center Association
North Carolina Justice Center
North Dakota Medical Association
Ohio State Medical Association
UHCAN Ohio
Oklahoma State Medical Association
Oregon Medical Association
Oregon Pediatric Society
Pennsylvania Chapter, American Academy of Pediatrics
Pennsylvania Medical Society
Rhode Island Medical Society
South Dakota State Medical Association
Tennessee Medical Association
Center for Public Policy Priorities (TX)
Children’s Hospital Association of Texas
Texas Academy of Family Physicians
Utah Chapter, American Academy of Pediatrics
Utah Health Policy Project
Utah Medical Association

Voices for Utah Children
Vermont Medical Society
Vermont Office of the Health Care Advocate
Virginia Chapter, American Academy of Pediatrics
Virginia Organizing
Northwest Health Law Advocates
Seattle Cancer Care Alliance
Washington Chapter, American Academy of Pediatrics
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Chapter, American Academy of Pediatrics
Wisconsin Medical Society

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