July 3, 2014

Jolie H. Matthews  
Senior Health and Life Policy Counsel  
Executive Headquarters  
National Association of Insurance Commissioners  
444 North Capitol Street, N.W., Suite 700  
Washington, DC 20001-1509

VIA Electronic Mail

Dear Ms. Matthews:

The Physicians Advocacy Institute (“PAI”) is a 501(c)(6) organization whose mission is to advance fair and transparent payment policies and contractual practices by payers and others in order to sustain the profession of medicine for the benefit of patients. PAI was founded as a result of settlements in class action multidistrict litigation (“MDL”) alleging unfair payment practices against several of the nation’s large for profit health insurers. Nineteen state medical associations were among the class action plaintiffs in the MDL litigation, and continue to participate actively in the PAI’s advocacy efforts.

We are pleased that the National Association of Insurance Commissioners (NAIC) is working to revise the NAIC Model Managed Care Plan Network Adequacy Model Act and appreciate the opportunity to participate as an interested party to the NAIC Network Adequacy Work Group’s efforts. We respectfully offer this initial set of comments and look forward to providing more specific input as the Work Group tackles this important project.

Today’s health care marketplace is incredibly dynamic. Implementation of the Affordable Care Act (“ACA”) is challenging all health care system stakeholders - including state regulators, health carriers, providers, patients and the myriad businesses that support the system, including technology companies – to adapt to new marketplace rules. Across the nation, federal, state and private health care exchanges are offering a diverse array of new health insurance “products” to consumers. This adds to choice but can also cause confusion, which regulators are scrambling to address with initiatives that promote transparent, “apples to apples” comparative information. We applaud these efforts as critically important to
consumers as they consider their options and select the most appropriate health insurance plan to meet their needs.

In this rapidly changing environment, it is more challenging than ever for state regulators to ensure the adequacy of provider networks that carriers establish to provide health care benefits to their beneficiaries. There is growing consensus about the need for consistent and specific network adequacy standards. To help guide state regulators in this process, we urge the NAIC Work Group to view its charge broadly to address the range of contractual and other factors that impact network adequacy, several of which we outline in this comment letter.

**PAI Recommendations for a revised NAIC Network Adequacy Model Act**

We recommend that this Work Group develop a comprehensive revised Model Act that provides a roadmap for network adequacy assessment in the marketplace of today and tomorrow. In our view, this includes: (1) providing guidance for states as they continue to utilize technology to more efficiently assess network adequacy; and (2) addressing the need for key consumer protections for problematic practices that undermine the adequacy and stability of provider networks and are increasingly common in the marketplace. As the Work Group defines its scope of work in these initial discussions, PAI respectfully urges it to consider the following recommendations for issues to address within the revised Model Act.

1. **The Revised Model Act should recommend that states establish specific network adequacy standards to enforce across all health plans.**

The current Model Act delegates considerable authority and discretion to health carriers to define and demonstrate network adequacy. Specifically, Section 5 of the current Model Act, entitled “Network Adequacy,” relies on each health carrier to maintain a network that is “sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.” It is left to the carrier to demonstrate that it meets its self-defined standard through “reference to any reasonable criteria used by the carrier.” The health carrier is then asked to file an access plan to demonstrate that it meets this vague standard, absent any “proprietary or competitive” information and update it whenever it makes “any material change.”

In light of the increasingly “narrow” networks health carriers are assembling, the approach of the current Model affords undue discretion to health carriers and insufficient instruction to states looking to the NAIC for guidance in this area. We urge the NAIC to use this process to adopt a Revised Network Adequacy Model Act that provides guidance to states about the importance of establishing specific, consistent and transparent network adequacy standards to apply to health plans that are marketed in the state. While each state will have its own geographic and provider demographics to consider as it adopts network adequacy standards,
the Revised Model should clearly lay out a regulatory process and establish model standards that states can adapt as necessary based on these state-specific characteristics.

The Texas Medical Association has provided detailed recommendations for network adequacy standards that PAI commends to this Work Group for consideration in the revised Network Adequacy Model Act.

2. The Revised Model Act should ensure that “Narrow” or “Tiered” Network Plans Meet State Network Adequacy Standards.

The insurance reform provisions in the Affordable Care Act eliminated many of the tools payers have utilized historically to manage risk. One remaining risk and cost containment tool is health carriers’ ability to establish provider networks with minimal regulator interference. In many markets, and particularly within plans marketed on public and private health care exchanges, health carriers are offering increasingly “narrow” provider networks as a means of controlling costs.

PAI and other provider organizations are extremely concerned that in many situations, “narrow” networks are constructed to exclude physicians and other health care providers who care for patients with medical conditions that require costly care. We view this as a “back door” method of re-implementing the risk selection that the ACA intended to eliminate.

Similar to the increased use of “narrow” provider networks, many carriers are using “tiering” or related mechanisms to steer beneficiaries to lower cost (and supposedly higher quality) contracted providers. We have several concerns about how this is being done in many instances. As it relates to network adequacy assessment, however, our main concern is that the selection of providers within the preferred tier (with the lowest beneficiary copayment responsibility) can be very limited.

When health carriers utilize “tiering” that promotes certain in-network providers over others, either by financial incentives or other more subtle marketing mechanisms, we strongly urge NAIC to assess network adequacy based on the preferred network of providers, exclusive of any other tier of providers. Health carriers may argue that network adequacy assessment should include the entire contracted provider network, including those providers in a non-preferred tier (often with a higher beneficiary copayment responsibility). However, those providers are often priced out of the reach of many beneficiaries, rendering the in-network benefit illusory.

To ensure against adverse selection masked as quality-based “tiering,” the process should be transparent and should include disclosure of any criteria used by health carriers to tier providers. The revised Model Act should recommend that state regulators establish rules requiring permissible tiering criteria to include only valid standards and measures and includes
due process for physicians who want to contest the designated tier. The Texas Medical Association comments are comprehensive on this point and PAI recommends them to this Task Force.

**3. The Revised Model Act should establish Standards for Accurate and Accessible Provider Directories.**

A serious problem that is closely tied to inadequate provider networks is that of inaccurate provider directories. There is growing evidence, both anecdotal and supported by recent surveys, that there are pervasive inaccuracies in many of the provider directories published by carriers. These inaccuracies take many forms, all of which mislead regulators regarding the sufficiency of a provider network.

This is extremely disruptive to beneficiaries’ ability to access appropriate providers and causes administrative hassles for physicians and other health care providers who are inaccurately listed in the provider directory. In many cases, the directory information is years’ outdated, listing physicians who have retired, died or moved out of state. Often times, non-contracted physicians are listed as contracted, and vice versa, causing confusion and in some cases, an unexpected financial burden for patients treated by a physician who they mistakenly believe was in network. Out-of-date information regarding contracted providers, such as wrong addresses, credentials, etc., also causes significant confusion and unnecessary hassles for patients and providers alike.

There has been little incentive for payers to ensure that their provider directories are as accurate as possible. In our view, that needs to be addressed. **Without accurate provider directories, there can be no true assessment of network adequacy.** The adage of “junk in, junk out” holds true for the relationship between the provider network information filed with states and regulators’ ability to assess network adequacy. In our view, the NAIC must address this problem if it hopes to produce a new model Network Adequacy Rule that will improve state regulatory oversight in this area.

The Work Group should expect to hear that it is outside of the scope of this Model Act to provide guidance for states to address provider directory inaccuracies, and that establishing stricter standards for payers to maintain accurate provider directories will be costly and unduly burdensome. Given the critical role provider directory information plays in any meaningful network adequacy assessment and the growing importance to patients and providers of transparent and comparative information as various health plan offerings enter the market, we urge NAIC to stand firm against those who argue against standards for accurate and transparent provider directory information.
There is increasing public awareness of this problem. Continued media coverage detailing examples of blatant inaccuracies will undoubtedly drive pressure for states to address the deficiencies through legislative and regulatory initiatives. We expect that states will move to address this problem with tools that exist today. One approach that we understand is being discussed is a requirement that health carriers collect an active email address for every contracted provider. This would facilitate an automated verification process through which payers or regulators could routinely engage in a statistically valid sample of listed providers. Health carriers that fail this initial random sample would be required to engage in a third party phone-based audit. Failing this audit would lead to remedial action.

There also are efforts to require payer attestation of the accuracy of provider directory information submitted to regulators. Putting teeth into this requirement is needed, however, and should be expected as this issue garners more public attention.

At the national level, there is an initiative underway at the electronic standard setting organization ASC X12 to develop a national electronic standard transaction for provider directories that would facilitate collection and reporting of consistent information across payers. This would yield more accurate information for consumers and regulators alike. Although this process will take some time, PAI believes it has potential to dramatically improve the quality and accuracy of provider directories across the nation.

We urge this Task Force to review the initiatives underway and consider how NAIC can best guide states as they work to ensure provider directory accuracy.

4. The revised Model Act should provide a regulatory roadmap for states to adopt an electronic approach to network adequacy oversight.

Given the challenge of implementing more stringent network adequacy standards for a significantly greater number of health plans in today’s marketplace, we believe that states will soon make a rapid transition to electronic network adequacy regulation. To prepare for this, it is important that the revised Network Adequacy Model Act establish a model regulatory framework and specific provisions necessary to support and facilitate electronically driven network adequacy regulatory processes.

Automated network adequacy compliance and review is vastly less burdensome than states’ traditional paper and map-based approach, and holds the potential to transform what has been a tedious and expensive network compliance review process for states and regulators alike. Once adopted, the benefits of automation are system-wide, including:
• Regulators would have much more sophisticated and administratively efficient network adequacy assessment capabilities, including the ability for ongoing monitoring, assessment, and remedial processes with minimal additional expense or staff time.

• Regulators also would have significantly enhanced capability to assess highly specific network adequacy metrics, including additional physician specialties, with little administrative burden. They also can conduct “best possible network” assessments.

• Automation facilitates assessment with simpler ("meets/does not meet") scorecard information that enables payers to adjust provider panels to meet specific deficiencies.

• Health carriers would be relieved of the expensive, time-consuming practice of submitting detailed paperwork and maps to document the adequacy of their networks.

• Automation supports efforts to provide more accurate and transparent information for patients, including accurate provider directory information. Payers would be required to submit on a regular basis in a stipulated electronic format their complete provider directory with all relevant information, including physician specialties. Any modifications to the provider network (based on terminations, additions, etc.) would be submitted immediately so that regulators could continually assess the adequacy of the network.

Automated network adequacy is already in place for Medicare Advantage plans. The technology exists today, and we expect this to become the way network adequacy assessment is done across the country for all health plans in the near future. We urge NAIC to provide leadership in guiding states towards widespread adoption of these technologies through a well-considered state regulatory framework.

5. The Revised Model should prohibit “without cause” provider terminations immediately prior to or within the plan year.

The PAI joins medical associations across the nation in voicing concern over the growing trend of health carriers issuing “without cause” terminations to contracted providers immediately prior to or during the plan open enrollment period. These abrupt and often unexpected terminations cause significant access interruptions for patients and can undermine network adequacy. In many cases, patients select a particular health plan based on the network status of their primary care physicians or a specific hospital or health system. When this “preferred” provider is unilaterally terminated immediately before the upcoming plan year, the patient is deprived of the benefit of this informed selection.

This “bait and switch” approach of untimely provider terminations by payers must be addressed. Toward that goal, PAI supports language in state law that all “without cause” terminations occur prior to a specified period (e.g., 60 days) before the start of the open
enrollment period for the next plan year. PAI also supports a provision that “cost” cannot be considered “cause” for terminations. This would address provider terminations that mask adverse selection by health carriers.

In conclusion, PAI looks forward to continuing to work with this Task Force as it develops the Revised Network Adequacy Model Act. We welcome the opportunity to discuss in greater detail the issues raised in this comment letter or any other topic of interest to physicians and patients. For any questions, please contact Kelly Kenney, PAI Advocacy Counsel, at k2strategiesllc@gmail.com or 312-543-7955.

Sincerely,

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President, Physicians Advocacy Institute, Inc.
Executive Vice President/CEO, North Carolina Medical Association

cc: PAI Board of Directors
Mary Jo Malone
Kelly Kenney