American Hospital Association

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October 29, 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: NAIC Health Benefit Plan Network Access and Adequacy Model Act as Adopted by the Regulatory Framework (B) Task Force

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

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) strongly supports many of the provisions of the Health Benefit Plan Network Access and Adequacy Model Act (Model Act) as approved by the National Association of Insurance Commissioners' (NAIC) Regulatory Framework (B) Task Force.

Network adequacy is a significant issue for patients and providers, and the AHA thanks the NAIC, staff and the commissioners for the many opportunities to participate in the nearly 18-month, deliberative process. In general, we believe that the latest draft represents a significant improvement over the outdated 1996 Model Act. **Specifically, the AHA believes that the revised Model Act would help address the problems providers and consumers face with respect to the lack of transparency and inadequacy with some health plan provider networks, as well as the financial burdens that result from these deficiencies.**

Of particular importance to our hospital members is the provision on "surprise bills" to protect consumers from unexpected large bills and balance billing. The proposed revisions address balance billing for planned services that are provided at in-network health care facilities that may use health care professionals who are not in the same health

plan's network. The proposed changes to the Model Act would increase transparency of health plans, in-network hospitals and out-of-network health care professionals. It also would include a structured mediation process between the out-of-network health care professional and the health plan when the health plan's payment approach is not considered reasonable by the out-of-network health care professional. **The AHA supports the proposed revisions, which would create a balanced solution among providers, health plans and hospitals to better protect the consumer from unexpected bills.**

However, we believe that the Model Act could be strengthened to better ensure access for children and adults to covered services. The three areas we would urge the B Committee to focus on are:

- **active approval of networks prior to products going to market;**
- **the use of quantitative measures to determine network adequacy; and**
- **regulation of tiered networks to prevent discriminatory network design.**

We believe our recommendations, which are outlined below, would ensure that state legislatures and insurance commissioners (Commissioners) would be better equipped to establish reasonable, meaningful standards for network adequacy, while still allowing for geographic and market flexibility and choice.

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

The current draft 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. **The AHA strongly recommends that the Model Act be revised to require prior approval of access plans by the Commissioner.**

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.

The AHA believes that, given a changing health care environment with rapidly evolving network designs, regulators should 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 would prevent consumers from purchasing an inadequate product and experiencing access problems or unexpected out-of-pocket costs at the time care is needed.

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

The current draft Model Act provides states with several options for the use of quantitative measurements to determine network adequacy. The AHA believes that a clear set of numeric quantitative standards are necessary to assure network adequacy. **We recommend that the Model Act require that Commissioners adopt, through required rulemaking, 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.**

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 also may leave consumers without clearly enforceable rights, as consumers would 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 & Medicaid Services (CMS) requires Medicare Advantage plans to meet quantitative standards, and it recently proposed that states must adopt quantitative standards for Medicaid managed care plans. Many states also use quantitative standards in their health maintenance organization and/or preferred provider organization markets.[1] Such standards would establish a floor that network plans must meet in order to be deemed sufficient, and provide essential consumer confidence that the network plans have met those standards.

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

The AHA is pleased to see a focus on providing greater transparency with respect to tiered networks in the current draft of the Model Act. Tiered provider networks – networks that assign different levels of consumer cost-sharing to different tiers of providers – are on the rise. We are concerned that providers that may subspecialize and care for patients with more complex needs may be placed into higher cost-sharing tiers,

[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.

forcing patients (children and adults) 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.

To prevent discriminatory or inadequate plan designs that would not ensure that all covered benefits are available at the expected cost-sharing levels, **the AHA recommends that you apply all network adequacy standards to the lowest cost-sharing tier of any tiered network.** The lowest cost tier should include a full range of providers for all covered services. 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 becomes discriminatory and costly to the consumer.

Thank you for your consideration of our recommendations. We urge the B Committee to consider these recommended changes to the Model Act before approving and sending it to the full NAIC for adoption. We look forward to working with you to continue to strengthen the final Model Act.

If you have any questions about this proposed revision, please contact me or Molly Collins Offner, AHA director of policy, at (202) 626-2324 or mcollins@aha.org.

Sincerely,

/s/

Ashley Thompson
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