



POLICY & ACTION FROM CONSUMER REPORTS

January 12, 2015

Mr. J.P. Wieske
Wisconsin Office of the Commissioner of Insurance
Chair, NAIC Network Adequacy Model Review (B) Subgroup
c/o National Association of Insurance Commissioners (NAIC)
444 North Capitol Street, N.W., Suite 701
Washington, D.C. 20001

ATTN: Jolie Matthews, NAIC Senior Health and Life Policy Counsel

Re: Consumer Representatives' Recommendations for Changes to NAIC's Revised Network Adequacy Model Act

Dear Mr. Wieske, Ms. Matthews, and Network Adequacy Model Review (B) Subgroup Members:

Consumers Union, the advocacy and policy division of the nonprofit Consumer Reports, offers these comments to the NAIC's Revised Network Adequacy Model Act. We appreciate your focus on updating and strengthening the Model Act since access to primary and specialty care providers and accurate information at the point of shopping for a policy are vital to consumers getting the full value of their insurance premium dollars. As you know, this has been an area of growing concern as plan offerings are changing and many carriers have narrowed their networks.

Further, for the many people who have never had health insurance before the concept of "participating" and "non-participating" providers is especially bewildering, insurance terms are confusing, and understanding the full cost-share implications and appeal options regarding in-network and out-of-network care is beyond their grasp. For all consumers, the financial consequences are serious, affecting how readily they can seek needed health care. See http://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html?_r=1

We support the comprehensive comments and suggested edits submitted by the NAIC Consumer Representatives (hereinafter "consumer-suggested revisions"). However, we write this letter to highlight and suggest further strengthening of a few provisions.

Balance billing protections (see consumer-suggested revision definition in Sec. 3(A) and consumer-suggested revision Sec. 6(C))— the draft Model Act's proposed revisions meant to improve affordability of and access to non-participating (out-of-network) providers when needed to achieve adequate networks are welcome and necessary. In addition, we appreciate the provisions aimed at better informing consumers receiving care at in-network facilities about the risk of being served by non-participating providers there, and we provide suggested improvements to those sections below ("Disclosure and Notice" Sec. 7). Yet, without protection from balance billing, the cost of out-of-network care can be overwhelming for consumers.

Some protection from onerous and unforeseen out-of-network costs may be achieved by contract provisions between issuers and providers, as proposed in consumer-suggested

revision Sec. 6(C), but in our experience the better approach, which several states have already taken, is a direct bar to such balance billing. See <http://kff.org/private-insurance/state-indicator/state-restriction-against-providers-balance-billing-managed-care-enrollees/>; and <http://www.chcf.org/publications/2009/04/unexpected-charges-what-states-are-doing-about-balance-billing>. If provisions in contracts between carriers and providers are the sole protection, consumers are left to assert their rights as third-party beneficiaries to the contract, a huge hurdle for lay people, potentially requiring them to bring or defend legal action.

In summary, we strongly recommend that the Model Act ensure balance billing protection for consumers from surprise bills by out-of-network providers in three situations: (1) where alternate access to a non-participating provider at in-network prices is necessary to get needed care but the type of medical provider is otherwise not available within the network, as anticipated by proposed revisions to Sec. 5(C); (2) in emergency situations where the consumer would not have the opportunity to research; (3) where the consumer has received services at an in-network hospital that used out-of-network providers, such as emergency room doctors, anesthesiologists and pathologists. This linked report, for example, illustrates the magnitude of this problem in one state, showing the many in-network hospitals in Texas for three of the largest insurers have no in-network emergency room doctors. http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf

We urge NAIC to add the following language to Sec. 6:

In no event shall a non-participating provider collect or attempt to collect from a covered person the difference between the provider's charge and the health carrier's allowed amount when the covered health care service is subject to [consumer-suggested revision] Sec. 5(C)(2) or when health care services were rendered at an in-network facility.

In the alternative, at a minimum, we urge you to add a "Drafting Note" alerting state regulators to consider legislation to specifically bar such balance billing:

Accreditation standards— Reliance on accreditation standards in lieu of explicit state standards is problematic if state law simply deems health carriers relying on such standards for network adequacy compliant with state law. Such deeming may evade state authority and public accountability. While accreditation has value, it is essentially a self-regulating process the result of which may be shielding information from both the public and state regulators. We support the comment by the consumer representatives on this point related to the Sec. 4 Drafting Note. In addition, Consumers Union suggests making explicit that if a state relies on an accreditor's standards, it may do so only if those standards are at least as rigorous as the NAIC Model Act; that "deeming" be prohibited; that carriers remain under authority of the state licensing entity and all its regulatory requirements; and that all accreditation standards and filings must be available to the state and the public.

Quantitative Network Adequacy Requirements—Consumers Union supports the quantitative criteria as proposed by the consumer representatives since the "bright lines" they provide allow the regulators to best monitor and, if appropriate, take enforcement action to ensure adequate networks. There is longstanding precedent in some state laws for quantified timely access standards for getting an appointment, currently in Sec. 5(B)(2)(b), and we urge their incorporation as specific requirements in Sec. 5(B)(1). Then states, through their regulatory process, may adopt the appropriate allowable wait times for different types of services. See, e.g., California Health and Safety Code Sec. 1367.03 requiring the State Department of Managed Health Care to create quantitative standards; and California Department of Insurance's regulation, California Code of Regulations, Title 10, Sec 2240.15.

Moreover, state regulators need to set limits on the degree to which carriers may count toward meeting network adequacy "participating facilities" that have very few, if any, physicians with

admitting privileges. We have seen this as a recent problem in several states. See, e.g., Texas study cited above. Listing such a facility as in-network presents a misleading picture to the regulator of the scope of the carrier's network. State regulators should set limits on, or disregard in assessing adequacy of networks, participating hospitals that do not have any or many in-network doctors with admitting privileges. Furthermore, Carriers with such in-network hospitals should identify them to the public (see comment below re. Disclosure and Notice, Sec. 7)

We, therefore, recommend that you enhance the quantitative requirements by adding the following **to Sec. 5(B)(1)**:

- “(f) Maximum allowable wait times for an appointment with a primary care physician, specialist, and other health care provider, taking into account the urgency of care” [see similar current consumer-suggested factor for consideration Sec. 5(B)(2)(b)]
- “(g) The degree to which in-network physicians are authorized to admit patients to, or, in the case of hospital-based physicians, practice at in-network hospitals.” [see current consumer-suggested factor for consideration Sec. 5(B)(2)(f)]

Amending “Access Plans”—the Proposed Model Law revisions contain a Drafting Note to Sec. 5(F)(3) suggesting that states might want to consider defining “material changes” in networks that would require re-filing an access plan with the Department. Consumers Union urges requiring quantification of material changes that require re-filing. Again, bright lines provide clarity for the regulated entity and for enforcement. For example, in California both the Department of Managed Care and Department of Insurance require reporting of material changes including, but not limited to, those that hit a 10% change in the providers in a network. California Code of Regulations, title 28, Section 1300.52(f) and title 10, Section 2240.5(d)(6).

Using provider directories as a cross-check on network adequacy— Provider directories are one set of the carriers' representations to state Insurance Departments that can provide a sensible, concrete check-point against network adequacy standards and access plans. Tying provider directories to network standards also can provide an extra incentive for carriers to keep the directories accurate. Consumers Union suggests the following additions to Sec. 6:

“(U) The carrier shall certify to the department that the information provided in the provider directory is consistent with the information required under other provisions of the Act, including the carrier's access plan. The carrier shall assure that other information reported to the department is consistent with the information provided to enrollees, potential enrollees and the department pursuant to this section.”

Disclosure and Notice Regarding Non-participating Providers at Participating Hospitals— We support the proposal in Section 7 to inform consumers when a consumer may be subject to services by a non-participating provider at an in-network facility. This would help avoid onerous “surprise medical bills.” We suggest that, in addition to carriers notifying such consumers who are *pre-certified* for services at in-network facilities, as in the consumer-suggested revision, carriers also provide a warning in the online and paper provider directory of any in-network hospitals that have no or few in-network providers.

We suggest the following addition to Sec. 8(A)(4):

“(g) Clear and conspicuous notice of which, if any, participating hospitals have no participating physicians or other providers in specific specialties, including but not limited to emergency services, or few such providers according to state-established minimums.”

Provider directory updates—Section 8(A)(2) of the proposed revision suggests that carriers “...update each network provider directory as least monthly.” While we applaud the Model Law revision proposing a standard for regular updating, we strongly believe that issuers should update online provider directories more frequently than the suggested once per month.

As we noted in recent comments on this topic to CMS, carriers keep extremely current about which providers are in their networks in relation to their claims payments. In this age of electronically available directories, we see no reason why that information, so vital to consumers choosing and using their health policy, cannot be shared with consumers in an equally timely way by updating carrier web sites in an ongoing manner every week or more frequently. Indeed, the California Commissioner of Insurance, the Hon. Dave Jones, recently issued regulations requiring that carriers' website directories be updated weekly. California Code of Regulations, title 10, Section 2240.6(b).

In addition, whatever the frequency of update, we recommend that directories clearly indicate when they were last updated.

We, thus, recommend amending Section 8(A)(2) as follows:

"The health carrier shall update each network plan provider directory at least weekly...."

We also recommend adding a new provision Section 8(A)(4)(g) as shown:

"(g) The date the directory was last updated."

Requiring provider directories to show whether provider is currently accepting new patients—The adequacy of carriers' networks is difficult for consumers to judge, lacking any overall measures of network breadth and depth. Viewing the directory is one current, though limited, way for them to get a sense of the breadth and to pin down whether particular providers are participating. However, when listed providers are not accepting new patients but that fact is not disclosed, this listing creates a false impression. We recognize that a provider's status as accepting or not may shift over time, but it is an essential piece of information to be displayed and updated. We note that the recently proposed federal regulations, section 156.230(b), would require Qualified Health Plans' provider directories to indicate which providers are not accepting new patients. Consumers Union recommends adding as required information to be shown in the directory online whether the provider is accepting new patients. Some carriers' provider directories do display this information currently, but it needs to be offered by all.

Thus, to Sec. 8(C)(1) Consumers Union suggests adding a new provision (f) as shown:

"(f) Whether the provider is currently accepting new patients."

We look forward to your further action to update this important Model Act, and appreciate your consideration of these comments. If you have any questions about these comments, please contact me at 415-431-6747 or bimholz@consumer.org.

Sincerely,



Elizabeth M. Imholz
Special Projects Director