January 12, 2015

J.P. Wieske  
Chair, NAIC Network Adequacy Model Review (B) Subgroup  
National Association of Insurance Commissioners  
444 N. Capitol Street NW, Suite 700  
Washington DC 20001  

Dear Mr. Wieske:

On behalf of the nearly 38 million AARP members and millions more individuals enrolled in health plans regulated by state insurance departments, thank you for the opportunity to provide the National Association of Insurance Commissioner’s (NAIC) Network Adequacy Model Review (B) Subgroup with comments on proposed revisions to the Managed Care Plan Network Adequacy Model Act (Model #74). AARP supports the NAIC’s efforts to revise this model law and update the language last amended in 1996.

In a health care environment that is changing in response to provisions of the Affordable Care Act, it is important to ensure that appropriate consumer protections are in place to reflect the altered environment. In particular, the recent move by some health insurers to reduce the size of their networks calls for a re-examination of current network adequacy policies and we commend the NAIC for proposing revised standards.

In 2014, over 8 million individuals signed up for health coverage under state and federally facilitated marketplaces, 48% of whom were ages 45-64.¹ For the millions who are newly insured, and for those who have been insured for many years, navigating the complexities of insurance products – locating providers, understanding benefit parameters and new terminology, and using benefits – will be enormously challenging. We hope that the revisions to the NAIC model will provide a rigorous framework to improve state oversight of network design, regulation of insurers, and consumer access to primary care providers and specialists.

¹ Addendum to Health Insurance Marketplace Summary Enrollment Report, October 1, 2013 - March 31, 2014, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014.
We have reviewed the Subgroup’s final draft and offer the following comments to further strengthen the model to protect consumers.

**State regulations are the best vehicles for specific quantitative standards** – The drafting note, following Section 5(B), points out that some states have adopted specific quantitative standards to define the adequacy of networks, such as time and distance, wait time, and number of provider standards. AARP supports the adoption of strong quantitative standards, but believes that these standards are best promulgated through state regulatory processes rather than specified in this model Act or codified in state laws. In our view, this approach provides states with necessary flexibility to adopt standards appropriate to their respective needs and allows states to modify the standards expeditiously as the need arises. When establishing their own quantitative standards, states should consider the time and distance standards adopted by the Medicare Advantage program. We recommend that this process of developing the regulatory standards be public, fully transparent, and open to multi-stakeholder input.

**Provider directories should be robust, whether online or in print** – AARP has been very concerned about the reports of shortcomings in plan provider directories for the 2014 plan year, including their lack of availability, confusion as to which directory applies to which plan, outdated information, and lack of standardization among plan directories (including different Web site search functions that make it hard to compare providers across plans). Some states have put in place improvements for 2015, but still more needs to be done.

Require both online and print directories to include meaningful information for consumers – While we recognize that it may not be practical for all of the information available in online directories to also be available in print directories, we encourage the Subgroup to require that as much meaningful information as possible be available in both versions. One important example is to include information about the language(s) spoken by providers in both versions. Carriers should also be required to include information in print directories with the web address for the online provider directory and a list of the categories of additional information that can be found in the online directory, as well as a toll-free telephone number option.

Provider performance should be integrated – Both online and print versions should include information about a provider’s performance. While more detail can be provided in the online version, the print version should, at a minimum, include a summary score to help consumers differentiate among plans on the basis of quality and cost. The National Committee for Quality Assurance (NCQA), in its outline of model provider directories, suggests that health carriers include an entry indicating a provider’s knowledge and experience as well as information pertaining to how the provider meets certain performance measures.² We recommend you incorporate this information into the list of

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requirements, or at least include a reference to the NCQA model in a drafting note for state regulators to consider in order to make directories more robust.

Standardization across health plans would improve consumer experience – We recommend requiring a standardized template for provider directories across carriers and plans. Standardization for all QHPs would make it easier for consumers to compare networks and understand which providers are included. AARP believes the Exchanges should facilitate such comparisons to encourage consumers to annually review their plan selection to ensure it continues to best meet their needs.

Provider directories should be accurate, up-to-date and changes conveyed to consumers –

Accuracy requirements should be strengthened – Section 8 (A)(2) requires that health carriers “update each network plan provider directory at least monthly.” The drafting note following Section 8 suggests that states consider additional requirements to improve the accuracy of provider directories. We support requirements that health carriers frequently update their provider directories. While requiring monthly updates is an improvement, this may still leave some consumers without access to accurate information. We urge states to consider adoption of requirements to further improve accuracy, such as requirements for carriers to conduct regular audits of providers and inclusion of notice requirements in provider contracts. Strengthened requirements are necessary to ensure that consumers have current, reliable information.

Health carriers should be required to provide notice – During the plan year, a QHP may see changes to its provider network, due to a variety of reasons. Consumers are often unaware of these changes until they go to the directory to identify a specialist or other provider. We recommend that significant changes to the provider directory during the plan year regarding provider participation -- particularly those involving existing relationships consumers have with a provider(s) -- trigger health carriers to notify consumers of the change, as soon as possible and to the extent possible. We encourage regulators to determine the most appropriate categories of policyholders who should receive this notice in order to ensure that the notices are reasonable and meaningful to consumers. We suggest that regulators establish standards to include appropriate required timeframes and method of delivery.

Accreditation of network plans should tie directly to regulator review – The drafting note following Section 4 addresses the plan accreditation process. We agree that private accreditation should not be a substitute for state regulatory oversight. However, accreditation by nationally recognized, private entities is an appropriate way to avoid duplicative reviews and to conserve resources for both the state and health plans. We also agree that the state should conduct a cross-walk between the accreditor’s standards and its own requirements to ensure the state’s requirements are met. We would have no objection if the accreditor’s standards exceed those of the state. We recommend that the drafting note specify that an accreditor’s
processes and standards should be reviewed by the state at least every three years to ensure they remain in compliance with state requirements.

**The use of tiered networks should be regulated as part of the model law** – Currently the model discusses tiered networks only in drafting notes. We believe that protections for tiered networks are a significant issue and should be included in the body of the model. The narrowing of benefits and access within network design can potentially limit the quality of care available to a consumer and limit the consumer’s ability to receive needed care. We recommend that the Subgroup include language in Section 5 that requires health carriers to provide full disclosure for each tier with respect to both cost sharing and quality.

**Surprise billing for in-network services should be addressed** – AARP is concerned by the increasing number of reports about consumers who have received large bills associated with hospital stays and procedures from non-network providers who provided services without the consumer’s knowledge or consent in an otherwise in-network setting. AARP believes it is critical to insulate consumers from out-of-pocket costs that result in such situations. We believe it is patently unfair for consumers to be “in the dark” about the possibility they might receive non-network services, and then be billed for out-of-network charges for such services. Safeguards that go beyond transparency requirements are essential to prohibit surprise billing and to limit consumer responsibility to in-network cost-sharing amounts. Furthermore, any balance billing charges should be negotiated between the plan and the provider. New York recently passed legislation improving disclosure and limiting consumer liability in these situations and several other states are considering similar legislation in 2015. We strongly recommend that the Subgroup look to these bills, and other research on the issue, and incorporate language in Section 7 that protects consumers from surprise billing.

**Changes to the Model Law should be consistent with Federal regulations** – We appreciate that HHS is waiting for the NAIC to revise its Network Adequacy model before it makes significant changes to network adequacy policy for QHPs under the federal marketplace. However, HHS recently issued a proposed rule for the 2016 Notice of Benefit and Payment Parameters, which addressed some network adequacy issues, such as transitional care for ongoing courses of treatment, provider directory requirements, and access to essential community providers. We think it is important that the requirements for network design, transparency, and enforcement should be consistent, to the extent practical, across the various sets of standards, including the NAIC Model, federal rules guiding QHPs in the Marketplaces, and regulations for Medicaid Managed Care plans and Medicare Advantage plans. Aligned standards will eliminate needless administrative costs and permit comparisons across programs.

In conclusion, AARP appreciates the efforts of the Network Adequacy Model Review (B) Subgroup – commissioners, state department of insurance staff, and stakeholders – to come to agreement on a strong draft through careful deliberations. Thank you for the opportunity to comment and contribute to this effort.
If you have any questions, please do not hesitate to contact James McSpadden on our Government Affairs staff at jmcspadden@aarp.org or 202-434-7706.

Sincerely,

Joyce Rogers
Senior Vice President, Government Affairs

Cc: Jolie Matthews