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: Comments on NAIC’s Proposed Revisions to the Managed Care Plan Network Adequacy Model Act (#74)

Dear Ms. Matthews:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to provide comments to the National Association of Insurance Commissioners’ (NAIC) Regulatory Framework (B) Task Force’s Network Adequacy Model Review (B) Subgroup’s proposed revisions to the Managed Care Plan Network Adequacy Model Act (#74).

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society (ACS), supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation’s leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Approximately 1.66 million new cases of cancer are expected to be diagnosed in the United States in 2015.1 Cancer patients – including those who are newly diagnosed, in active treatment, and survivors – often need access to specialists (e.g., oncologist, surgeon, radiologist – including subspecialists). Even short gaps in coverage – or delayed access to care – can lead to significant disruptions in care for individuals with cancer and can result in negative health outcomes. That is why it is so critical that issuers offer robust networks of providers and for issuers to allow individuals access to out-of-network services, when medically appropriate. ACS operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance options that may be available to them in their area. HIAS representatives often hear from individuals whose cancer treatments are delayed due to problems associated with their health insurance coverage – in particular, problems accessing needed specialist.

Cancer treatments can be very expensive and cancer patients incur significantly more out-of-pocket costs compared to individuals with no history of cancer. The average annual out-of-pocket costs (excluding health insurance premiums) for an adult under age 65 without a history of cancer is $590. An individual who is recently

diagnosed with cancer will spend an average of $1,463 in out-of-pocket costs (excluding premiums) and an individual who previously was diagnosed with cancer will spend an average of $1,182 in out-of-pocket costs (excluding premiums).²

ACS CAN supports the NAIC’s efforts to revise and update its Network Adequacy Model Act to ensure that consumers have access to the providers, products, and services they need when medically necessary. We join other groups in offering revisions designed to improve the Model Act to be more consumer-friendly. Our red-lined comments are attached to this letter. The following summarizes our red-lined comments on the revised Network Adequacy Model Act:

Network Adequacy

ACS CAN applauds the NAIC for requiring plans to maintain a network that is sufficient to provide enrollees with access to a sufficient number and type of providers (including primary, specialty, and subspecialty providers) to meet the needs of the enrollees.

Tiered networks: As more health plans adopt tiered networking arrangements, it is important that state laws and regulations reflect this fact. Many plans utilize a tiered network for providers. Cancer patients often need to utilize providers in higher network tiers – like cancer centers of excellence or specialized oncologists – but are unable to do so due to the higher cost-sharing associated with higher tiers. We urge the NAIC to encourage states to review a plan’s tiered network to ensure that the plan is not discouraging individuals with certain diseases or conditions, like cancer, from enrolling in a plan by placing access to all specialized providers in the highest tier.

Sufficiency of the network: ACS CAN urges the NAIC to adopt quantitative criteria to ensure that a plan’s network meets a minimum sufficiency standard. Specifically, ACS CAN recommends the NAIC include a minimum ratio of providers to covered persons for primary care physicians and specialists (including subspecialists); minimum number of full-time providers to meet the needs of individuals with limited English proficiency; and, a maximum time and distance standard to access hospital, emergency care, diagnostic and ancillary services. Individuals who enroll in a health plan must be ensured that their plan provides basic coverage for their health care needs – including access to oncology services, if necessary.

Access plans: ACS CAN urges the NAIC to include in its Model Act requirements that plans must submit to a state insurance commissioner an access plan that stipulates how the plan intends to meet the network adequacy requirements. Plans should be required to provide this information on a prospective basis and require the insurance commissioner’s prior approval of the access plan (Option One). ACS CAN urges the NAIC to remove its proposal (Option Two) to allow states to permit a health plan to simply maintain an access plan on file and make the plan available to the insurance commissioner if requested.

Out-Of-Network Services

Cancer patients often need to access out-of-network specialized providers for their cancer treatment. However, many health plans do not provide any coverage for out-of-network services, making it difficult for cancer patients to access specialized out-of-network services without significant out-of-pocket costs. Last year ACS CAN conducted an analysis to determine the extent to qualified health plans (QHPs) offered in the Marketplace provided adequate provider networks for oncologist services and the availability of out-of-network coverage.³


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Our analysis revealed that overall 43 percent of the unique silver QHPs available through the federally-facilitated marketplace on healthcare.gov, Covered California, and NY State of Health did not offer any out-of-network coverage.

We support the NAIC’s proposed revisions to require that plans maintain a process to allow plan enrollees the ability to obtain a covered benefit from a non-participating out-of-network provider. We urge the NAIC to clarify that, in these instances, individuals should have their cost-sharing count toward their maximum out-of-pocket limit.

**Balance billing:** We are concerned that individuals who utilize out-of-network services are subject to balance billing, which occurs when the out-of-network provider’s costs exceed the issuer’s in-network payment rate, leaving the individual responsible for the difference (in addition to any cost-sharing required by the insurer). Balance billing charges can be quite significant – particularly if the issuer provides no or nominal reimbursement for a service, leaving the enrollee to essentially cover the entire cost of the service. We urge the NAIC to require that a facility that is designated as being in-network be prohibited from balance billing for any services provided by an out-of-network health care professional employed or contracted by the facility.

**Second opinions:** For serious conditions like cancer, individuals often need access to a second opinion regarding their treatment options. We urge the NAIC to require that in such instances enrollees be permitted to obtain a second opinion from an out-of-network provider for the price of in-network cost-sharing if no alternative in-network provider is available, qualified, or within a reasonable distance. If the first and second opinions are in conflict, the carrier should be required to cover a third option.

**Appeals**

Some individuals with rare conditions – like some cancers – need access to specific specialized providers, who may not be included in a plan’s network. ACS CAN urges the NAIC to include in its Model Act an appeals mechanism to allow consumers the ability to access providers – including specialist care and subspecialty care if needed. The appeals provisions should contain requirements by which the plan must act on any appeals request, including an expedited appeals process requiring the carrier to notify the provider and enrollee of its decision within 24 hours in cases where the enrollee has an emergency medical condition.

Plans should be required to keep a log of any appeals filed by an enrollee. We note that similar provisions exist in the Medicare program. States should review this log as a check and balance on the adequacy of a plan’s network.

**Continuity of Care**

Cancer patients rely on the expertise of a specialized provider (e.g., an oncologist, radiation oncologist, and surgeon) throughout their cancer journey (from point of diagnosis, through active treatment, to survivorship). Switching providers during the course of active treatment can disrupt a patient’s care and could jeopardize the outcome. We urge the NAIC to provide additional safeguards to ensure that individuals with serious medical conditions, like cancer, who are currently in active treatment have access to their provider throughout the course of their treatment.

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Provider Directories

ACS CAN supports provisions that require plans to provide accurate and current provider directories. These directories should provide consumers – both current enrollees in the plan as well as prospective enrollees – with information they need to determine what providers are covered by the plan, including whether a provider is accepting new patients. Simply listing that a provider is included in the plan’s network is insufficient.

Plans directories should be written in plain language so that the average consumer is able to determine which providers are included in the plan’s network. We have heard from individuals who have expressed frustration that the provider directories contain inaccurate information. In one instance, an individual specifically chose a plan based in part on the hospital covered by the plan. This individual (and the hospital) believed the hospital to be included in the plan’s network. After the individual underwent a procedure she was informed that the hospital was not included in the plan’s network and thus the individual was assessed thousands of dollars in out-of-pocket costs. In this case, the provider directory for the plan listed fewer providers (including the specific hospital) depending on whether the individual logged into the site as a member versus visiting the site as a guest.

In addition, plans should list specialty and subspecialty of each provider, if applicable. Earlier this year, ACS CAN conducted an analysis to determine the extent to which cancer patients could obtain information regarding whether a plan contracted with a particular oncologist. Our analysis revealed that in general plans provided coverage of oncologists, but that it was often difficult to determine the number and range of oncology-related providers included in a plan’s network.

Disclosure and Notice Requirements

The revised Model Act requires issuers to provide written disclosure or notice for a covered benefit that is provided at an in-network hospital when there is the possibility that the covered person could be treated by a provider that is not included in the hospital’s network. While we support the NAIC’s notice and disclosure requirement, we urge the NAIC also to consider requiring issuers to notify consumers of any options available to them for access to an in-network provider. Simply informing the consumer that s/he may be liable for significant charges for anesthesia services, for example, fails to provide appropriate consumer protections.

In addition, we urge the NAIC to require that States actively monitor the extent to which carriers are issuing written disclosures or notices. States should take this information into account when determining whether a plan meets the network adequacy requirements.

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4 Id.
Conclusion

On behalf of the American Cancer Society Cancer Action Network we thank you for the opportunity to comment on the Regulatory Framework (B) Task Force’s Network Adequacy Model Review (B) Subgroup’s proposed revisions to the Managed Care Plan Network Adequacy Model Act (#74). If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org or 202-585-3261.

Sincerely,

Dick Woodruff
Vice President, Federal Relations and Strategic Alliances
American Cancer Society Cancer Action Network