Dear Ms. Matthews:

The Center for Medicare Advocacy (Center) greatly appreciates the opportunity to comment on the draft language to the Plan Network Access and Adequacy Model Act released by the National Association of Insurance Commissioners (NAIC).

The Center, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality healthcare. We draw upon our direct experience with thousands of individuals and their families to educate policymakers about how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that beneficiaries receive the health care benefits to which they are legally entitled, and to the quality health care coverage and services they need.

Comments on Selected Sections:

Section 2: Purpose of the Act

We support the Model Act’s inclusion of “transparency” in its purpose section. As discussed in more detail below, it is essential that consumers have current, accurate information regarding the adequacy and accessibility of their plans. This addition underscores NAIC’s position that transparency is a central focus of any regulation regarding network access and adequacy.

Section 4: Applicability and Scope

Drafting Note to Section 4. We support this drafting note, which encourages states to insist upon independent assessments of network adequacy instead of relying on accreditation from third party evaluators. States should not hand over this regulatory responsibility and should, instead, use accreditation as yet another data point upon which to evaluate plan networks, alongside its independent review.

Section 5: Network Adequacy

Drafting Note to Section 5, regarding tiered networks. While we support the inclusion of this drafting note directing states to view tiered network designs with increased scrutiny to ensure
that a seemingly broad network is not, in fact, overly restrictive because of the high-cost sharing associated with higher tier providers, we encourage NAIC to include such heightened scrutiny in the model language itself.

Section 5, C. 1. Please clarify the change from “no greater cost to the covered person than if the benefit were obtained from participating providers,” to “an in-network level of benefits from a non-participating provider.”¹ The language change, as currently written, may not include clear enough consumer protections against balance billing. We are concerned that this language change does not protect against out-of-network providers billing beneficiaries for the difference between the provider’s charge and the health carrier’s allowed amount for in-network services. Specific language about cost from the perspective of the beneficiary is essential.

Section 5, D. 1. We support the change from “ensure reasonable proximity” to “ensure reasonable access,” which reflects that inappropriate barriers to accessing in-network care are not only geography-based, and that access to care is the important measure to evaluate, rather than proxies for access, like geographic proximity.

Drafting note to Section 5, E. Option 2, (a); (b). We support the language in the Model Act regarding the aim of ensuring that access plans are publically available. As the Drafting Note states, the exemption for proprietary, competitive or trade secret information is not a catch-all for information that the plan does not wish to share; the language in the drafting note emphasizes that the default for the access plan should be public. We share NAIC’s concern that plans could attempt to claim that their entire plan fits under this exemption. Therefore, we support further narrowing the language in 2(b) to reflect that only limited information that would otherwise be private should be included in the exemption for public posting.

Section 5, F. We support the inclusion of numbers 4 and 7 to this section on requirements for the access plan. These additions require plans to make available publically, in consumer-friendly language, the criteria used to build their provider network, and their processes for updating their provider directories. We support the inclusion of additional efforts for plans to make their processes and information transparent for consumers.

Section 6: Requirements for Health Carriers and Participating Providers

Section 6, F. 3. We support the change from prohibiting selection of providers that would allow plans to “avoid” high risk populations to prohibiting selection criteria that could “discriminate against” high risk populations. We interpret this language change to more broadly prohibit selection criteria that would adversely affect high-risk groups and their interaction with the plan than those that would only impact enrollment or participation. We also support the inclusion of a drafting note confirming that the broader term “discriminate against” includes avoidance and

¹ NAIC Draft Language, Sec. 5, C. 1.
other adverse consequences of selection criteria and is not meant to imply a requirement of intent or malice.

Section 6, H. We support the inclusion of appeals information in the required education from the plan to providers. Providers are often the first line of assistance and support for patients who must pursue an appeal with their health insurer.

Drafting Note to Section 6, L. 1. a. We agree that movement of providers from one tier to a higher tier can have significant negative consequences for patients. We therefore encourage NAIC to include the substance of this drafting note, and the one on page 12, into the text of the model rule, requiring notice and opportunities for exceptional circumstances in this situation as well as when a provider has been dropped from the network entirely.

Section 6, L. 1 b. While we support the increase from 15 days to 30 days’ notice to affected patients of the mid-plan year change in their doctor’s network status, we encourage NAIC to consider a further increase to require at least 60 days’ notice.

Drafting note to Section 6, L. 3. We urge NAIC to include the note regarding special enrollment periods into the text of the Model Act. The Drafting Notes cite the need for a special enrollment period for consumers, “when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.”

A special enrollment period is an essential consumer protection that is necessary for beneficiaries who find themselves without in network providers in the middle of their contract term. Without a special enrollment period, beneficiaries may face continuity of care issues, and delays in necessary treatments. We urge this Drafting Note to be included in the text of the Model Act.

Section 8: Provider Directories

We support the inclusion of this section, as it will provide updated information for consumers. The Model Act language requires provider directories to be posted online, and updated at least monthly in order to provide accurate information. We support posting this information online, as printed provider directories become outdated and therefore inaccurate essentially immediately. We also support language underscoring the need for information to be accessible for beneficiaries with limited English language proficiency and disabilities. The Model Act requires information on health professionals to include whether they are accepting new patients. This is a crucial element, as a network is not adequate if a contracted provider simply practices within a certain time or distance from a beneficiary, but is not accepting new patients.

Also, we urge NAIC to include a requirement, similar to Medicaid, that directories report information regarding languages other than English spoken by providers.

Additionally, we would like to encourage the Drafting Note following this section be incorporated into the text of the Model Act language. Particularly, we encourage the inclusion of the requirement that health carriers internally audit their directories and modify directories based on audit findings to reflect accuracy of contact information, whether the provider is actually taking new patients, and to monitor consumer complaints.
Thank you for the opportunity to provide these comments. For further information please contact Center Policy Attorney Kata Kertesz at kkertesz@MedicareAdvocacy.org.

Sincerely,

Kata Kertesz