January 12, 2015

J.P. Weiske
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Re: Recommended Revision to the Managed Care Plan Network Adequacy Model Act (#74)

Dear Mr. Weiske and Ms. Matthews:

On behalf of our more than 200 hospital and nearly 50 health system members, the Illinois Hospital Association (IHA) appreciates the opportunity to comment on the draft revisions to the Managed Care Plan Network Adequacy Model Act. IHA is grateful for the Subgroup’s attention to the important and complex issues addressed in the draft.

Below are IHA’s comments on the draft. We look forward to addressing these issues at the next Subgroup meeting.

1. **Section 2. Purpose**

   Subsection (B)(2) indicates that the purpose of the Act is to establish “requirements for written agreements between health carriers offering managed care network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons;”

   IHA believes the focus of the purpose section should be directed to the oversight of carriers in the marketplace. As such we recommend the language be changed to more closely reflect the draft definitions of “Health Benefit Plan” and “Health Carrier” in Section 3.

   **IHA’s recommended change for subsection (B)(2) reads as follows:**

   [Details of IHA's suggested change]
“Establishing requirements for written agreements between health carriers offering managed care network plans and participating providers regarding the standards, terms and provisions under which the participating provider the carrier will provide covered-benefits to covered persons, deliver, arrange for, pay for or reimburse any of the costs of health care services;”

2. **Section 3. Definitions**

a. **Subsection (F)** currently establishes the definition for “Emergency Services.” IHA believes the current definition is too restrictive and applies only to hospital services. This definition would seem to exclude such items as ambulance and other emergency services that might be delivered outside the four walls of a hospital.

**IHA recommends a more expansive definition of “Emergency Services,” perhaps language reflecting Illinois’ definition from the Managed Care Reform and Patient Rights Act (215 ILCS 134/10):**

“Emergency services” means transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition.

b. **Subsection (P)** establishes the definition of “Network” to mean “the” group of participating providers. In reality, many carriers may establish a network through the combination of several groups.

**IHA recommends changing the definition as follows:**

P. “Network” means the group or groups of participating providers providing services to under a network plan.

3. **Section 5. Network Adequacy**

**Subsection (C)(1)** establishes the carrier’s process for ensuring network access for covered persons. The draft language deletes the past reference which protected consumers for greater out-of-pocket costs when forced to use an out-of-network provider due to an inadequate network. **IHA continues to object to the deletion of this protection.** The language inserted, ostensibly to replace this protection, simply limits the carrier’s liability to an in-network rate. Because an out-of-network provider may balance bill the patient for the difference between the negotiated reimbursement rate and billed charges, the consumer is left unprotected even though the cause of the extra billing
was due solely to the inability of the carrier to provide in-network coverage.

**IHA strongly urges to subgroup to amend the subsection as follows:**

C. (1) A health carrier shall have a process to assure a covered person obtains a covered benefit at an in-network level of benefits from a non-participating provider such that the covered person incurs no greater out-of-pocket expenses than had that person used an in-network provider, or shall make other arrangements acceptable to the commissioner when:

4. **Section 6. Requirements for Health Carriers and Participating Providers**

a. **Subsection (L)(1)(c) of the draft establishes notification requirements for covered persons when a provider leaves the network. In addition, the subsection requires providers to notify the carrier, within five days, of all covered patients being seen by the provider. IHA believes this requirement would establish an unnecessary administrative burden on providers that not only might be unable to be met by the provider, but would also be unenforceable as being outside the usual jurisdiction of the Department of Insurance.**

IHA fully supports the need for cooperation between carriers and providers when a change in a network is imminent. We would suggest however, that such cooperation be a matter of the contractual agreement between the two parties and based on the realities facing the two parties at the time of the separation.

**IHA therefore recommends the language be amended as follows:**

(c) Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier. Requirements for providers leaving a network to provide the carrier with a list of covered persons receiving active treatment from the provider shall be established by the two parties upon entering the contract.

b. **Subsection (M) prohibits the assignability of rights and responsibilities under a network contract by the provider. IHA believes**
that such a prohibition should be established for both parties to promote full transparency.

IHA recommends the following change to the draft language:

M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider or either party without the prior written consent of the health carrier or other party.

c. This change, in addition, would negate the need for the Drafting Note that accompanies this subsection.

IHA appreciates your and the Subgroup’s efforts to address the many challenges in updating this Model Act. We hope you find our comments helpful and we look forward to discussing these issues with you. If you have any questions about the comments, please contact Bill McAndrew at (217) 541-1179 or bmcandrew@ihaustaff.org.

Sincerely,

William R. McAndrew
Senior Director
Illinois Hospital Association