January 12, 2015

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Senior Health and Life Policy Counsel
National Association of Insurance Commissioners
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RE:  Health Benefit Plan Network Access and Adequacy Model Act: Model # 74

Dear Ms. Matthews:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to submit comments on the Health Benefit Plan Network Access and Adequacy Model Act: Model # 74, to the National Association of Insurance Commissioners (NAIC). We thank and commend the NAIC and the Network Adequacy Model Review Subgroup for the thoughtful, measured approach to updating and strengthening the NAIC model act. The results of this approach are clearly evident in the latest draft language.

LLS supports the proposed model act language, which closely mirrors the LLS’ network adequacy principles, attached to this letter for your reference. The model language provides substantial patient protections and we strongly support the additions made to the previous model.

At the same time, as a patient organization committed to ensuring timely access to care for patients with life-threatening cancers, LLS believes that the proposed model language should be further strengthened through a series of edits outlined below. These recommendations are intended to clearly proscribe patient protections that insurers should consider when implementing new network designs and to ensure greater transparency for consumers purchasing health insurance. These recommendations for enhancing the proposed model language are captured in the specific comments section below.

About LLS

LLS is the world's largest voluntary health agency dedicated to the needs of blood cancer patients. Each year, over 150,000 Americans are newly diagnosed with blood cancers, accounting for nearly 10 percent of all newly diagnosed cancers in the United States. LLS exists to find cures for leukemia, lymphoma, and multiple myeloma and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. LLS funds lifesaving blood cancer research, provides free information and support services, and advocates for public policies that address the needs of patients with blood cancer. Since our founding 65 years ago, LLS has invested over $1 billion into medical research, and LLS-funded research has been part of the vast majority of FDA-approved therapies for blood cancer.
Specific Comments

A. **Tiered Networks** [pg 5, drafting note] – Regulatory oversight of network sufficiency is especially important as it applies to new approaches to health carrier network designs, such as tiered networks. The current draft language includes only a drafting note related to tiered networks. Given that tiered networks may be designed in different ways such that not all covered services are provided in every tier, it is critical that consumers be made aware of what services are included, or not included, at the point of sale. Therefore, NAIC should expand the current language to include the following items in the final model language, rather than in a drafting note, to require carriers to:

- Publically disclose differences in network design, particularly as it relates to “tiered networks”;
- Communicate to potential consumers reviewing the plan whether the consumer can access all network health care providers in every network tier;
- Ensure the lowest cost-sharing tier includes access to all covered services and meets network adequacy requirements, and
- Protect against higher cost sharing when the health carrier does not have a network provider of the required specialty (blood cancer) with the required professional training and expertise to treat or provide health care services for the condition or disease, or when such provider specialist leaves the network tier.

Without these protections, carriers would be in violation of non-discrimination provisions in law\(^1\).

B. **Inclusion of non-network providers as in-network providers** [pg 6, paragraph C(3)] – LLS fully supports the draft language requiring that carriers “treat the services provided by a non-network provider as if the services were provided by a in-network provider” when the health carrier “does not have a type of participating provider available to provide the covered benefit”, or “when the condition or disease requires specialized health or medical services”. We applaud the subgroup for this provision, which helps protect patients from exorbitant out-of-pocket expenses frequently associated with accessing care from providers not in their carrier’s network. This protection is especially critical for blood cancer patients for whom a bone marrow transplant or immunosuppressive therapy is routinely part of the standard treatment regimen. These types of treatments require access to specialists or specialty centers—such as National Cancer Institute-designated cancer centers or transplant centers—which may not be part of the standard plan network.

C. **Access plans** [pg 7, paragraph E, options 1 & 2] – LLS supports requiring each health insurer to submit an access plan to the state commissioner for each network plan the carrier offers in the state. Certain non-proprietary aspects of those plans should be publicly available and readily transparent to current and prospective consumers what services are covered in the plan. These items include: which providers are included in the plan, what out-of-pocket costs a consumer can expect to pay, a complete and current drug formulary, and provisions to specifically address access for patients with complex and chronic care needs.

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\(^1\) ACA §1311(c)(1)(A).
D. **Quality Metrics** [pg 10, paragraph F(3)(c)] – While quality metrics are an important tool in analyzing provider quality, it is important to ensure plan metrics are routinely updated and meaningful for the care provided, in order to account for the quality of specialty care providers. For instance, broad metrics such as re-hospitalization rates for all patients may not be applicable when measuring the quality of specialized oncology provider. Given the significant advances in quality metrics being developed by medical societies and insurers, LLS recommends that the model language reference the need for routine updates for these tools.

E. **Quantitative Standards** – LLS supports regulators establishing quantitative network adequacy standards that hold insurers accountable for ensuring a sufficient network of care providers. Insurers should be held to more than one or two standards that simply measure time and distance to various providers. LLS recommends the NAIC consider the inclusion of clear, meaningful, and measurable quantitative measures in the network adequacy regulatory paradigm.

Changes in care delivery and new payment models will require transparent mechanisms to judge whether health plans have robust provider networks that ensure patient access to evidenced-based medical care. Because many of these care innovations (e.g. telemedicine, care coordination) can improve access to and the quality of care for patients, it is critical that regulators and other stakeholders examine and update current standards for network adequacy in new models of care to ensure that the focus remains where it belongs – ensuring patient access and transparency.

LLS recognizes the inclusive nature of these recommendations and hopes that the NAIC will incorporate the substantial progress made to the model language thus far and consider ways to further strengthen the model act through the recommendations we have outline above. If you have any questions about our comments or our organization, please do not hesitate to contact Bernadette O’Donoghue (by email at bernadette.odonoghue@lls.org or by phone at 202-989-1810) or Brian Rosen (by email at brian.rosen@lls.org or by phone at 202-989-1806) for further information.

Sincerely,

Brian Rosen
Chief Policy & Advocacy Officer
The Leukemia & Lymphoma Society