Here are my thoughts on the NAIC Network Adequacy Model. Mostly technical, but a few substantive points, in order of appearance:

* If an “intermediary” means anyone sitting between a carrier and a provider in the chain of contracting, I’m not sure it makes sense to treat them all the same way under the Model. (And if it doesn’t, we need to figure out what it does mean and get a definition that works.) I can think of at least four types of “intermediaries,” without totally bright lines between them: subcontractors acting on behalf of carriers, subcontractors acting on behalf of providers or provider groups, “rent-a-network” administrators dealing at arms’ length with both carriers and providers, and specialty subnetwork administrators.

* As suggested in DC, I’ve attached some possible language for consideration to address “tiering” or other differential incentives to use some participating providers rather than others, with the regulator considering them when reviewing the overall reasonableness of the network and access plan.

* As I’ve said before, I don’t think a network is truly “adequate” if there’s no way to know for sure that you’re accessing in-network services because you’re always at risk of waking up to a balance bill from your anesthesiologist. I had a surprise recently – a pleasant one – to open a bill from a radiologist from last fall’s encounter with The System and see that it was for a $8.75 network copay! (It was also amusing to get a bill with the personal note “Thank you for choosing Maine Pathology South for your healthcare needs.”)

* However, there are also strong arguments that in many markets, this approach simply isn’t realistic. In those markets, carriers can’t insist that hospitals use participating providers because the providers will work only with less demanding hospitals. So as an alternative, I have also suggested a “half a loaf” proposal where patients in HMOs or closed-panel plans can get a guarantee of benefits at the network level without balance billing.

* Finally, I think the original Model got on the wrong track when it took a sensible provision – the network provider’s obligation to provide covered services and hold the patient harmless from balance billing survives the carrier’s insolvency – and untethered it from the underlying insurance policy, so that the provider essentially steps into the shoes of the carrier and becomes directly obligated to provide benefits. It’s certainly important to take adequate care of patients in active treatment, but that doesn’t mean a network contract should make it the *provider’s* personal financial obligation whether or not the patient is still insured (especially now that patients are no longer at risk of being “uninsurable” when their coverage runs out). I’ve proposed insolvency language and continuity-of-care language that recognizes that provider contracts are supposed to be about the treatment of *covered* persons, but I recognize that others feel differently, and I’m probably the odd one out on this.

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