Pg. 1 Section 2 B (2) – is a broader statement more appropriate here? The purpose of the act is well beyond merely requiring public disclosure of access plans. Also, section 5 B itself doesn’t actually require public disclosure of the access plan. In my opinion, the purpose statement should speak to broader transparency goals, including provider directories, selection standards, etc., as well as the actual access plan. If the model is intended to require public disclosure of specifically the access plan (or any of those other pieces), then there should be somewhere in the model a specific provision requiring public disclosure. (I assume it’s in here somewhere and I just haven’t gotten to it yet.) It doesn’t seem like the purpose statement is the place for that. Also, in my state, we seem to often pass model laws without the purpose statement. So if that’s the only place where a disclosure requirement is made, we might miss that. As far as this section 2 B (2) goes, suggest striking what’s there in the revised draft and instead put something like: “Establishing requirements for public disclosure of plan documents that address the sufficiency of provider networks, including but not limited to the written access plan described in section 5 B of this Act.”

Pg. 2 Section 3 A – I suggest deleting “(non-participating)!”. We have had situations in the past in MO where providers under contract with a health plan, with a ‘hold harmless’ provision in the contract, balance billed anyway. It happens.

Pg. 2 Section 3 F – the definition of Emergency Services should not be so exclusively hospital based. Emergency services need to include the services rendered by EMTs or other personnel in the ambulance or wherever the patient in distress happens to be located. In fact, I don’t think the proposed changes are any better than the current definition, and prefer no change over the proposed change in this draft. This proposed change seems to preclude getting a patient to a provider with better treatment capabilities.

Pg. 3 Section 3 N (formerly 3 M) – I still suggest deleting the term “health indemnity plan” from the model. If instead you replace it with “non-network plan” then there wouldn’t seem to be any point in including it in Section 4 of the model.

Pg. 4 – NOTE TO SUBGROUP – the drafting note seems fine to me.

Pg. 4 Section 3 U suggest: “Telemedicine” or “Telehealth” means medical services provided to a covered person from a health care professional who is at a site other than where the covered person is located using telecommunications technology.” - - I replaced “covered benefits” with “medical services”. The services may or may not be “covered benefits” but they are still Telehealth. See the difference?

Pgs. 4-5 Sections 3 V and 3 W – the definitions of “To stabilize” and “Transfer” need to more clearly address situations where a patient goes from an ED to hospital in-patient, or from the ED to home. The proposed definitions seem too narrow. I suggest deleting “To stabilize”. I note that “stabilize” is not used in the revised model, except in proposed revisions to the definition of “emergency services”. I previously said I don’t support the revisions to the definition of “emergency services”. So in my opinion, the model does not require any definition of “stabilize”. The word “transfer” is used in the revised definition of “emergency medical condition” and I support that revision. “Transfer” is used elsewhere in the model as well. I’m not 100% convinced a definition of “transfer” is necessary, but if it is, it should incorporate transfer from any type of medical setting to any other type of medical setting, and also to non-medical settings such as home. Not sure there is any other non-medical setting to address, but maybe there is.

Pg. 5 – discussion of “Tiered” networks – I still think that it would be optimal for the model to contain explicit provisions regarding tiered networks. Telling states to pay close attention to what carriers advertise will not prevent plan designs with limited coverage in the best tier. Carriers can and will make sure to include
disclosures in their advertising that not all covered benefits are covered at the most optimal tier. That’s easy to do, but it doesn’t meet the need for actual “comprehensive” coverage to be available at the most optimal tier. In my opinion, it’s not in anyone’s best interest to foster a situation where a plan can bill itself as “comprehensive” (or MEC or EHB or MV or whatever you want to say), but to be designed to cover only limited benefits in the best network tier. Consumers have a history of “managed care backlash” as some may recall, and this method of regulating seems to invite another round of that sort of backlash. I don’t think that helps the industry any more than it helps consumers. I DO think a floor – a clear minimum standard – helps assure a level playing field, and that regulators have an obligation to work for that level playing field. I would like to see the model address tiered networks in a way that assures such plans are competing on a level playing field with plans offering less complex network designs. I would advise the working group to clearly keep in mind that the contract between the plan and the provider is not relevant to the consumer, who only experiences their own policy and the tiers in that policy. I hope that makes sense. This seemed to be a point of confusion in one of the calls earlier this year.

Pg. 7 – (4) at the top of the page preserves internal grievance/appeal rights. Why not external? Those also still apply, right? Suggest deleting “internal”. That word is acting like a limiter that I don’t think is desirable.

Thank you.

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