January 12, 2015

J.P. Weiske  
Chair, Network Adequacy Model Review (B) Subgroup

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Via email: JMatthews@NAIC.org

Dear Mr. Weiske and Ms. Matthews:

The National Multiple Sclerosis Society is pleased to write in support of revisions to the National Association of Insurance Commissioners’ 1996 Model Network Adequacy Act. We applaud the open and transparent processes used throughout the Subgroup’s deliberations and encourage state lawmakers’ future consideration of policies regarding network adequacy with this in mind. As described below, we write in general support of the proposed revisions to Model 74 and other recommendations from the NAIC Consumer Representatives, and are recommending certain additions to Sections 3 and 5.

Multiple sclerosis, an unpredictable, often disabling disease of the central nervous system, interrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are moving us closer to a world free of MS. Most people with MS are diagnosed between the ages of 20 and 50, with at least two to three times more women than men being diagnosed with the disease.

Compared to the general population, even people with mild forms of MS can have extraordinary healthcare, and therefore, health insurance needs. Fortunately, the majority of people living with MS have comprehensive health coverage, or are gaining it now through Exchange plans or Medicaid. They often turn to the Society for help understanding their coverage options, costs, plan rules and other obligations of coverage. At an annual estimated average direct cost per case of MS in the US of $39,000 (Adelman, 2013) it is not surprising that public and private payers alike seek to manage the costs of MS care through a wide range of delivery models and benefit designs. As a result, health plan enrollees with MS and their care providers are often among the first to experience new utilization review techniques and value incentives. With these experiences in mind, we offer the following comments to highlight our overall support.
Section 2 – PURPOSE

We are pleased to see the emphasis on transparency and assurance of information about access plans and accountability to maintain sufficient provider networks in the Purpose.

Section 3 – DEFINITIONS

Because Essential Community Providers (ECPs) are required for inclusion in Qualified Health Plan networks and referenced in the revisions (Section 5 E), we encourage including the term in the definitions. Likewise, tele-medicine or tele-health, preferred provider, tiered provider networks, ancillary services, specialty provider, pharmacy (or pharmacist, whichever is included in the revised model) are also important additions to the list of definitions. Additionally, especially because language in this model may apply to the adequacy of Medicaid managed care provider networks, we support the addition of definitions for service providers more commonly associated with them.

Please add “community based organization” and “peer provider”, per the recommendation of the American Association on Health & Disability.

Section 4 – APPLICABILITY AND SCOPE

We support the application of the Act to all health carriers that offer network plans, and also do not view accreditation by separate entities sufficient proof of a network’s adequacy. Accreditation should be seen as an additional tool for monitoring compliance with network adequacy standards only, not a substitution for it.

Section 5 – NETWORK ADEQUACY

Tiered Provider Networks: We appreciate the Subgroup’s concerns first referenced in Section 5 (also in Sections 6, 8 & 9) regarding tiered provider networks. We fear that the criteria being used to determine tier placement of highly specialized providers, such as MS specialists, may be unfair and discriminatory against high-cost patients. For example, we believe it unjustified and discriminatory to patients to tier providers at higher, more costly levels because the provider prescribes high-cost medications or MRIs, both of which are within the standard of care in MS. For this reason, we are especially supportive of the requirements that plans disclose the criteria they use for determining provider tiers and the costs to enrollees for using them (Section 5, (G) (4), and Section 6 (F)(1).

Sufficiency Standards: We are generally supportive of the proposed sufficiency standards outlined, and the possible approaches state policymakers may wish to take for requiring them in statute or rulemaking by the
commissioner. In all instances, it is critical that all requirements be applied to the lowest cost-sharing tier of any network, and that the results of compliance monitoring through patient surveys and other means be made publically available.

We also believe it is critical that pharmacy access be included in the final model. CMS has made it clear that it includes pharmacy access in its assessment of QHP network adequacy for FFM plans, as indicated in its 2016 letter to issuers (p.22): http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf. We do not believe that the NAIC should diverge from this approach.

Access to Out-of-Network Care: We believe that patients in need of care that is not accessible through participating providers without unreasonable delay should be held harmless against the costs of out-of-network care when necessary, but that a mechanism to assure such access must never substitute for a sufficient network. Circumstances that should assure coverage of out-of-network care at in-network rates should include the lack of a network specialist or subspecialist with the professional training, expertise and experience necessary to treat a condition or disease. (Emphasis added). While we would hope for the adoption of stronger ‘hold harmless’ consumer protections rather than a time-limited process for requesting out-of-network access, we appreciate that such processes are evolving. Absent those, we strongly support the inclusion of internal and external appeals processes as a reasonable mechanism for reconsidering requests for out-of-network care resulting in a denial.

Another circumstance that warrants special consideration involves the physical accessibility of treatment facilities. People with MS that rely on such devices frequently contact us requesting help identifying diagnostic and treatment facilities that are wheelchair accessible.

*Please add Section 5B (2) (h): the ability of network providers to accommodate patients relying on wheelchairs or other wheeled mobility devices.*

*And to 5C: the health carrier has an insufficient capacity to accommodate patients relying on wheelchairs or other wheeled mobility devices.*

Access Plan: We support the requirement for carriers to obtain prior approval of their access plan by the commissioner, and urge the elimination of the alternate option merely to file, but not gain approval of the Access Plan (Option 2). Additionally, with regard to required updating of the provider network, we support inclusion of a definition of material change (in Sec. 5 Drafting Note and Section 8D):

We strongly support the requirement that Access Plans include processes for updating provider directories, and methods for assuring coordination and continuity of care and appropriate discharge planning.

Continuity of Care Considerations: We strongly support the continuity of care provisions for patients in active treatment, as well as the call for states’ consideration of the implications on patients for contract

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terminations mid-year, and adoption of special enrollment periods in the event of contract terminations or incorrect provider directory information.

Section 8 – PROVIDER DIRECTORIES

Because inaccuracies in the provider directories have been widespread and known to be highly problematic to people with MS, we have strongly supported measures to improve the timely updating and ready access to verifiably accurate, machine readable provider directories in federal regulations. Likewise, we appreciate and support the standards for Provider Directories outlined in the draft revised Act.

Thank you again for this opportunity to comment and for your efforts related to revisions of this model Act. Please feel free to contact my colleague Ms. Kim Calder, NMSS Director of Health Policy (Kim.Calder@nmss.org) with any questions or comments.

Sincerely,

Bari Talente
Executive Vice President, Advocacy
National Multiple Sclerosis Society