January 12, 2015

Mr. J.P. Wieske
Wisconsin Office of the Commissioner of Insurance
Chair, NAIC Network Adequacy Model Review (B) Subgroup
c/o National Association of Insurance Commissioners (NAIC)
444 North Capitol Street, N.W., Suite 701
Washington, D.C. 20001
ATTN: Jolie Matthews, NAIC Senior Health and Life Policy Counsel

Dear Mr. Wieske,

The National Kidney Foundation (NKF) appreciates the opportunity to comment on the updated draft of the NAIC Health Benefit Plan Network Access and Adequacy Model Act. NKF is America’s largest and oldest health organization dedicated to the awareness, prevention, and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. In addition, NKF has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), including transplantation since 1997 through the NKF Kidney Disease Outcomes Quality Initiative (NKF KDOQI). NKF also provides professional and patient education, patient support services, and community health programs. We work with volunteers to offer the scientific, clinical and kidney patient perspective on what needs to be done to prevent kidney disease, delay progression, and better treat kidney disease and kidney failure. NKF has local division and affiliate offices serving our constituents in all 50 states.

We recognize this NAIC Model Act serves as a guideline to state departments of insurance and is influential in guiding each state’s rules regarding provider networks. As such the Model Act is essential to protecting consumers’ access to providers. When consumers use out-of-network providers their copayments or coinsurance do not apply to the out-of-pocket maximum and therefore it is critical that people with chronic conditions who require specialized services have an adequate network of providers so that they are not faced with healthcare expenditures that they cannot afford. There are 635,906 people nationwide with end-stage renal disease (ESRD)¹ who

require either a kidney transplant or dialysis survive. These individuals need sufficient access to dialysis facilities and transplant centers. While the majority of ESRD patients are covered by Medicare, others have private group or individual health insurance plans. As a result, we offer the following recommendations for incorporation into the NAIC Model Act.

Section 3: Definitions

In the definition of facilities, dialysis (ESRD) facilities should not be identified in the drafting note as limited to a consideration for states with Medicaid managed care plans as some dialysis patients may have insurance in the private market. We recommend removing that aspect of the drafting note and including dialysis facilities and transplant centers in the listed examples of healthcare facilities so that it is clear states need to consider the needs of ESRD patients in their regulations and oversight.

Section 5: Network Adequacy

While we recognize the intent is to provide a model guideline that allows for states to make modifications, we believe the network adequacy standards for facilities need to be specific and quantified. Dialysis facilities and transplant centers provide life-saving medical care to patients with kidney failure on a regular and ongoing basis. In our May 21, 2014 comments to this subgroup we proposed a minimum standard for in-network coverage of dialysis facilities to be a maximum commute of 30 minutes or 30 miles from the patient’s home. If there is no in-network provider within 30 minutes or 30 miles from the patient’s home the patient should be able to receive dialysis at that next nearest facility without regard to network status and without having to pay out-of-network cost sharing. In our previous comments we cited evidence associating an increase in adverse outcomes when patients are required to commute longer distances for dialysis. However, we acknowledge the preference to keep the model guidelines more general to allow for state flexibility in adopting them so at minimum we request that under Section 5: subsection B the definition of sufficiency include adhering to quantifiable standards for a minimum number of healthcare facilities (including dialysis and transplant centers), primary care providers, and specialty providers for different geographical areas (rural, urban, metropolitan, etc.) and a maximum distance from the consumer’s home.

In addition, NKF strongly supports the changes in Section 5: subsection C as they introduce a number of consumer protections that ensure patients with chronic conditions have the ability to access the care they need when a plan is out of compliance sufficiency requirements. Consumers should not have to pay higher costs to access the healthcare they need when a plan’s network is insufficient.
Section 6: Requirements for Health Carriers and Participating Providers

NKF supports the addition to Section 6 subsection F(3)(c), which specifies that carriers must account for the quality of care delivered when selecting network providers. Consumers should have access to high quality care and networks should include providers who achieve high performance on quality measures and patient outcomes.

NKF also supports the addition to Section 6 subsection L(2) and (3) as this allows people with chronic conditions, disabilities, and life-threatening illnesses the ability to maintain continuity of care or ensure a safe transition to another provider when necessary.

Section 8: Provider Directories

NKF supports the additions to the requirements for provider directories, which will allow patients to search by provider and facility type and receive helpful information to select a provider that best meets their needs with stronger assurance that the provider is still in the network. To better inform and protect consumers we recommend that the drafting note for this section (regarding contacting network providers, auditing the directories to ensure accurate information, and monitoring consumer complaints) be removed and incorporated into the requirements. Consumers should have the best possible assurance that providers, hospitals, and facilities listed as in the plan’s network contain accurate information.

NKF appreciates NAIC’s work on updating the Model Act and the improved, draft consumer protections.

Sincerely,

Tonya L. Saffer

Tonya L. Saffer, MPH
Senior Health Policy Director