January 12, 2015

Jolie Matthews
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001

Re: National Association of Insurance Commissioners Health Benefit Plan Network Access and Adequacy Model Act

Dear Ms. Matthews:

The National Patient Advocate Foundation (NPAF) appreciates the opportunity to submit comments on the National Association of Insurance Commissioners (NAIC) draft Health benefit Plan Network Access and Adequacy Model Act (hereinafter “the draft”). NPAF appreciates your continued work to ensure that the coverage and benefits in Qualified Health Plans (QHPs) sold through the Health Insurance Marketplace are accessible and affordable for patients, particularly those struggling with a chronic, debilitating or life-threatening disease.

Tiered Networks
NPAF appreciates the attention given to tiered networks, particularly the acknowledgement that such networks must be marketed appropriately so patients are made fully aware of such networks prior to enrolling in a plan. Network tiering creates barriers to access for patients in need of specialty care, many of whom are unable to afford the cost sharing requirements for providers placed on a tier that is subject to co-insurance. NPAF’s sister organization, Patient Advocate Foundation (PAF) assists patients with chronic, debilitating and life-threatening diseases with access and affordability issues. Many of the patients served by PAF are low income, and cite affordability issues as one of their largest barriers to access. In addition to ensuring that plans are employing the appropriate marketing techniques so that patients are aware of any applicable network tiering in the plans they are considering, NPAF encourages NAIC to consider dissuading issuers from imposing such tiering, due to the access barriers it creates for low income patients in need of specialty care. NPAF further encourages NAIC to emphasize to states the impact of network tiering on patients, which go beyond the need of issuers to market such network structure to potential enrollees.

NPAF appreciates that NAIC has recognized the hardships placed upon patients in plans with provider tiering, and appreciates that NAIC encourages issuers to consider such hardships. By noting that “states may want to consider the implications that consumers may face, including continuity of care and financial implications, when a participating provider is reassigned in the middle of a policy or contract year to another tier with higher cost-sharing requirements,” NAIC is highlighting an issue faced by many patients, who find that they are unable to afford services or continue treatment due to network tiering.
NPAF encourages NAIC to strengthen this language by requiring states to avoid policies that lead to such a result, rather than simply encouraging them to consider the implications of such policies.

NPAF is encouraged by the NAIC disclosure and notice requirements placed upon hospitals, in order to ensure that they notify patients that physicians or providers in their facility may not be covered by their plan’s network. However, further steps must be taken by plans to ensure that patients are able to receive comprehensive treatment at an in-network facility without being subject to higher cost-sharing or out-of-pocket requirements due to network tiering. Providing disclosure and notice is a good first step, but for many patients, their treatment is their primary focus and such notice and disclosure may not be thoroughly considered. Additional safeguards to protect patients from the financial implications of such provider tiering within a hospital or other large provider setting must be taken. If an issuer fails to provide enrollees with an adequate provider network within a facility such that they are unable to receive the care they need without unknowingly going outside of their plan’s network, NPAF encourages NAIC to ask states to adopt a policy similar to the emergency exceptions process proposed by the Department of Health and Human Services (HHS). Such an approach would allow access to needed medications that are not included in a plan’s formulary by providing an exceptions process through which such medications will be covered by the plan and/or counted toward a patients’ maximum out-of-pocket costs.

Network Adequacy

NPAF appreciates the efforts to clarify network adequacy requirements for states, including using measuring standards such as hours of operation, wait times, geographic accessibility, and provider to covered person ratios, among others. NPAF appreciates the acknowledgement by NAIC of the progress made in some states with respect to defining network adequacy by using standards such as maximum travel distances and maximum travel time. The patients served by PAF frequently identify transportation issues as a common access barrier. Many patients are too sick to travel long distances to receive treatment, and many low income patients struggle to afford the costs associated with transportation to and from their provider facilities. NPAF applauds the states that have taken steps to mitigate this access barrier and impose network requirements that take into account the time and distance a patient must travel to receive treatment, and encourages NAIC to incorporate such standards into this draft.

Patients often require medically necessary treatment, only to find that a provider is unavailable within their plan’s network. As such, NPAF appreciates the NAIC recommendation requiring issuers to outline a process through which patients may obtain a covered benefit from a non-participating out-of-network provider. NPAF would further encourage NAIC to recommend requiring issuers to meet similar marketing requirements to those used to notify potential enrollees of network tiering. Making patients aware that they may be able to access needed out-of-network treatment is critical in order to ensure that patients are able to receive the care they need.

NPAF is encouraged by the NAIC note urging states to “review other state laws and regulations and consider adding to them special enrollment periods to address potential issues consumers may face, particularly with respect to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be an in-network or a participating provider is listed as accepting new patients.” Many patients are making enrollment decisions primarily due to cost, because that information is most widely available. In addition to encouraging plans to conduct marketing and education to potential enrollees in order to ensure network information is readily available and easy to understand, the safeguards proposed above provide additional security to patients for whom the provider network is particularly important. Such
protections allow patients to continue their course of treatment and modify their enrollment decision in order to ensure their required providers are included in their plan. NPAF respectful asks NAIC to encourage states to adopt such standards, rather than to merely review other state laws addressing this issue, since it is one that impacts patients throughout the country.

**Transparency**

NPAF appreciates the addition to the access plan requirements, which sets, at a minimum, a requirement upon issuers that “(t)he health carrier’s process for making available in consumer-friendly language the criteria it has used to build its provider network, which must be made available through the health carrier’s online and in-print provider directories.” Transparency and accessibility of such information will contribute to patients’ ability to select a plan that provides adequate coverage and network adequacy to meet their individualized health care needs.

In addition, NPAF applauds NAIC for retaining such requirements related to addressing the needs of those enrollees with limited English proficiency and literacy, as well as those with diverse cultural and ethnic backgrounds. This step will help begin to address and eliminate health disparities among these populations.

**Active Treatment**

NPAF encourages NAIC to strengthen their definition of “active treatment” to go beyond “means regular visits with a provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.” NPAF is particularly concerned at the exclusion of routine monitoring for chronic conditions, as there is a wide range of chronic conditions requiring varying levels of treatment. Such a blanket exclusion could have unintended, unforeseen consequences. NPAF encourages NAIC to remove the exclusion of chronic conditions from the definition of “active treatment,” or at a minimum, clarify the language to ensure that patients are not adversely impacted by a narrow interpretation of the term.

**Quality Standards**

NPAF is encouraged by the decision to include a suggestion that states consider “requiring that an access plan include information on the health carrier’s efforts to ensure that its participating providers meet its quality of care standards and health outcomes for certain types of network plans, such as HMOs and narrow network plans that the health carrier has designed to include providers that have high quality of care and health outcomes.” Quality care is of the utmost importance to patients, so rather than suggesting that states consider such a requirement, NPAF encourages NAIC to recommend states take such action. Ensuring quality care for all patients who need it is an effort that involves all stakeholders, and health plans can play a critical role in seeking to include in their networks only those providers who have a track record of providing quality care if they are further encouraged to do so.

**Non-Discrimination**

NPAF appreciates that NAIC has added non-discrimination language to the draft, to ensure that networks are not crafted in such a way to dissuade patients from enrolling in plans based on intentionally inadequate provider networks. It is critical that affordable comprehensive coverage be made available to all patients who need it, and all efforts to ensure that robust networks are in place must be encouraged.

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Thank you for the opportunity to submit comments to this draft, and thank you for your continued efforts to ensure that all patients have access to affordable comprehensive health coverage.

Respectfully submitted,

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CEO

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