January 12, 2015

Jolie Matthews, Senior Health & Life Policy Counsel
National Association of Insurance Commissioners
700 Hall of the States
444 North Capitol Street, N.W.
Washington D.C. 20001-1509

RE: Comments on Health Benefit Plan Network Adequacy Model Act

Dear Ms. Jolie Mathews:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. We are writing to provide our comment and recommendations on the National Association of Insurance Commissioners (NAIC) Health Benefit Plan Network Access and Adequacy Model Act (#74).

Background:

NPAIHB represents 43 federally-recognized tribal governments that operate their own health care programs or have health care managed by the Indian Health Service (IHS), a federal agency within the U.S. Department of Health and Human Services. These services are provided to over 108,000 American Indian and Alaska Natives (AI/AN) located in the states of Idaho, Oregon and Washington. These individuals are eligible for Medicaid, Medicare, Children’s Health Insurance Program (CHIP), and private insurance plans offered by employers and through the federal exchanges established by the Affordable Care Act (ACA).

The network adequacy standards proposed by NAIC provide an opportunity to adopt standards to comport with the requirements of federal statutes and regulations that govern the federal Indian health system. These statutes and regulations deal with requirements of network adequacy, reimbursement, and special contracting requirements dealing with Indian health programs. Adopting our recommendations into the model Act will assist to include Indian health providers in insurance networks and protect AI/AN consumers, particularly those who live in remote geographic areas, and those who have unique cultural and linguistic needs.

In many cases, the primary care providers who are most geographically accessible and culturally appropriate are working in clinics and hospitals operated by Tribes, Tribal Organizations, and IHS. Because of this, it would make sense for health
carriers to include these Indian health providers in their networks; however, there are often barriers to this. The most common barrier is that services provided by the IHS, Tribes and urban Indian clinics are subject to federal regulations that may be different from state regulations and provisions in standard network provider contracts.

Recommendations

Section 3. Definitions:

(D) Essential Community Provider.

The Act includes a definition for “Essential community provider” and further acknowledges that even though it is not used in the draft Model Act it is defined to alert states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations.

Indian health providers are listed as essential community providers in the ACA and NPAIHB recommends that it would be helpful to carriers to mention that Indian health providers have ECP status.

(H) Health Care Professional.

The current definition is:

“Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

The final phrase—“consistent with state law”—could be problematic for Indian health providers as federal law allows professionals who are licensed in a different state to practice in Tribal and IHS facilities.

Indian health providers.

There are no definitions in the draft document related to Indian health providers. It would be helpful to add a definition for the term “Indian health provider.” We recommend the following definition:

*Indian health provider.* The term “Indian health provider” means any health program administered directly by the federal Indian Health Service; any tribal health program and any Indian tribe or tribal organization under the Indian Self-
Determination and Education Assistance Act (P.L. 93-638); or urban Indian health organization operated under the Indian Health Care Improvement Act (P.L. 94-437).

This will help to clarify federal requirements to include Indian health providers in federal health programs (Medicare, Medicaid, CHIP, ACA).

Section 5. Network Adequacy:

In general, we like the criteria of (3) geographic accessibility. However, the concept of (4) geographic population dispersion is contradictory. If people are living in remote areas, it appears there could be an exception to the geographic accessibility rule. While this may be reasonable under some circumstances due to the economic feasibility for locating health providers in some areas of the country; if Indian health care providers (or other types of providers) are already located in a remote area or areas with low population density, then the carrier should offer a network that includes the providers that are actually available.

Section 5(C) addresses the need to provide access to out-of-network providers if the network is inadequate. We recommend that the Model Act specify an additional category for obtaining a covered benefit from an out-of-network provider to specify that the AI/AN consumer can access services from an Indian health provider who is geographically accessible. This provision is already in law and regulations for Medicaid and QHPs.

Section 5(E)(3), the Model Act requires carriers to:

...notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The health carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an updated an existing access plan.

We recommend that the Model Act include language to put everyone on notice that there is a government to government relationship between CMS and federally recognized Indian Tribes and under Executive Order 13175, any “material change” to any existing network plan must adhere to the Executive Order. We understand states are not mandated to follow the Executive Order; however, CMS is and any program with their imprimatur should do so likewise. Ultimately, CMS is under an obligation to follow the Executive Order.¹

Section 5(F) of the Model Act requires carriers to submit access plans that describe or contain a number of required criteria. These requirements are good consumer protections and some are particularly appropriate for AI/AN communities, including items 1, 2, 4, 5, 8, and 9. In addition, in states that have Indian health providers, we recommend that plans specify how they will coordinate with Indian health facilities for referrals – this could be added to item 2.

We support the concepts of making the access plans and network lists public information. Additionally, we recommend that the Access Plan requires carriers in states that have federally-recognized Tribes to document their good faith efforts to include Indian health providers in their networks, as further explained in the following section on anti-discrimination provisions.

Section 6, Requirements for Health Carriers and Participating Providers

At Section 6(F)(3), we support the selection of providers in networks shall not be established in a manner that discriminates against high-risk populations by excluding providers because they are located in geographic areas or treat patients that contain a risk of higher than average claims, losses or health care services utilization. In some cases, it could appear that carriers that do not include Indian health providers in their networks are attempting to keep AI/AN out of their plans to reduce the number of people in high risk populations, while carriers may believe that the Insurance Commissioner requires them to adhere to other standards that prohibit them from contracting with Indian health providers. For example, carriers may require minimum liability insurance in their provider contracts, while most Indian health providers are covered by the Federal Tort Claims Act and not required to have liability insurance. Another example is that carriers may require providers in their network to serve the entire population, while Indian health providers may be limited to serving AI/AN. Unless there is an acknowledgement of the federal laws, such as the model Addenda that we have included, carriers may feel that they are required to exclude Indian health providers from their networks. We believe these issues need to be addressed explicitly in the Model Act.

One way that CMS has addressed network adequacy for QHPs in the federally-facilitated marketplace (FFM) is to require that all issuers make a good faith effort to offer provider contracts to all Indian health providers. Evidence of “good faith” would be to include the aforementioned Indian Health Addendum. In addition, “good faith” includes offering payment amounts to providers that are at least equivalent to the amount the plans are required to pay Indian health providers for services provided to enrollees as out-of-network providers under Section 206 of the Indian Health Care Improvement Act (IHCIA).

We strongly recommend that NAIC include these concepts in the Model Act, either in a special Indian health section, or in the section related to anti-discrimination. Furthermore, as we have learned from experience with the FFM, it is necessary for carriers to document and report their efforts and results in offering contracts with the Indian Addendum and payment rates equivalent
to IHCIA Section 206 rates. As noted above, we suggest that this be included in the Access Plan requirements.

Again, thank you for this opportunity to provide our comments and recommendations on the model act.

Sincerely,

[Signature]

Andy Joseph, Jr., Chairperson
NW Portland Area Indian Health Board
Colville Tribal Council Member