January 12, 2015

By email to jm matthews@naic.org


Dear National Association of Insurance Commissioners,

We have had the opportunity to review the November 12, 2014, version of the NAIC’s Health Benefits Plan Network Access and Adequacy Model Act, and we would like to share our suggestions and a few comments about its provisions.

Our perspective is that of advocates for access to comprehensive, quality, affordable health care for lower income individuals and families. The Shriver Center has worked for decades to expand and improve Medicaid and the Children’s Health Insurance Program. Our advocacy on health insurance issues is more recent, going back to pre-Affordable Care Act efforts in Illinois (our home state) to make insurance available and affordable to people who were not Medicaid eligible. With passage of the ACA we have been working for its successful implementation nationally and in Illinois. We have ongoing contact with the Illinois navigators who are assisting Illinois residents enroll in and understand public or private health coverage as part of the Illinois navigator training team and as the managers of HelpHub. HelpHub is an online technical assistance center where over 1800 Illinois enrollment specialists share their concerns and questions about ACA enrollment and have them answered quickly by policy experts and state and national policymakers. Our suggestions and comments on network access and adequacy are based on all that experience.

Section 3. Definitions.


We suggest that NAIC delete the language re “unexpected onset.” We think that retaining that language will open the door to health insurers denying coverage to insured individuals who have had previous episodes of a medical condition but may need to go to the emergency department while travelling away from their home area.

Regarding subsection F. “Emergency services.

We suggest that NAIC add language clarifying that the patient’s health insurance company is responsible for covering the cost of transferring the patient. Without such an express statement patients and the hospital providing the emergency services will not know who is going to be paying the transfer costs.

Section 5. Network Adequacy.

Regarding subsection C. We suggest that NAIC add “without unreasonable delay” to subsection C(1)(b). That language is included in subsection C(2)(b) (ii). We think it belongs in both subsections and its omission in C(1)(b)
could be read to suggest that it is not part of the calculation of when a person may see a non-participating provider without risk of higher costs to the patient.

We appreciate that “network adequacy” is not a one size fits all concept and approve the NAIC’s effort to outline reasonable criteria. We suggest that NAIC add language requiring carriers to make their network adequacy criteria public so that people considering enrolling in their plans and people enrolled in their plans can know what they will be or are getting. As you know, many people are new to private insurance and don’t know what to expect, that is, what is normal and adequate and what is not.

Section 6. Requirements for Health Carriers and Participating Providers.

Regarding subsection C(1). We suggest that NAIC expand the time period of covered services to a person in an inpatient facility for some period post discharge. As you know, many people are discharged from hospitals while they are still quite vulnerable and need follow up medical care. Patients should be able to have their providers see them through recovery beyond the hospital doors. We suggest you consider adopting something like the “course of illness” concept for the cut off date.

Regarding subsection (F). Here we have a comment, rather than a suggestion. Our comment is that we totally support NAIC’s efforts to prohibit discrimination against patients who may be considered high risk. With guaranteed issue required by the ACA, it is possible that insurance carriers will look to other ways to discourage enrollment by patients who need more or more expensive services. We think that not contracting with providers with expensive patient bases is one possible strategy.

Regarding subsection (L). Here, too, we have a comment and also have some concerns. We appreciate NAIC’s effort to prevent sudden changes in provider inclusion in a plan by requiring at least 60 days notice before terminating a contract without cause, by providing for notice to patients, and by requiring continuation of active treatment. However, we really do not like carriers and providers being able to back out of contracts without cause. Patients rely on the fact that certain providers are in their plan’s network when they enroll. Their interests are not well served when carriers and providers can change things midstream. We encourage NAIC to consider prohibiting terminating contracts without cause. Alternatively, we suggest that NAIC consider allowing special enrollment periods for patients whose providers exit their plan during the coverage period.

Regarding subsection L(2)(a)(ii). We suggest NAIC delete the section saying routine monitoring is not active treatment. We think that one of the most important health reforms is encouraging patients to work with physicians to get chronic conditions under some control and then actively monitor their status. We think the language saying “routine monitoring” is not active treatment is a step in the wrong direction and sends the wrong message to patients.

Section 7. Disclosure and Notice Requirements.

We suggest that NAIC find ways of addressing the underlying problem of in-network hospitals cooperating in having non-network providers, such as radiologists, pathologists, and anesthesiologists, treat covered patients. The disclosure requirements in the draft model law is helpful, but patients are simply in a very difficult situation when they are told that a non-network provider may attend them. Network providers, both physicians and hospitals, need to be required to take more responsibility here, and carriers need to demand that they do and assist them in doing so.
Section 8. Provider Directories.

We suggest that provider locations be required information for all providers and in all forms of directories. For many patients, but especially for low-income patients for whom transportation is always a challenge (Public transportation may not be available; They may not have access to a car.), the location of the provider is one of the most important factors in provider choice.

Thank you for this opportunity to submit suggestions and comments. We appreciate the immense effort NAIC has put into drafting this model law.

Please contact me at 312.368.3327 or mstapleton@povertylaw.org if you have questions or need clarifications.

Very truly yours,

Margaret Stapleton
Health Care Justice Director