January 12, 2015

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Chair, Network Adequacy Model Review (B) Subgroup  
National Association of Insurance Commissioners  
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Ms. Jolie H. Matthews  
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Re: NAIC Managed Care Network Adequacy Model Act Revisions

Dear Mr. Weiske and Ms. Matthews:

On behalf of the Urgent Care Association of America (UCAOA), I thank the National Association of Insurance Commissioners (NAIC) for responding to changes in the insurance market by undertaking the important task of updating the NAIC’s Managed Care Network Adequacy Model Act and for soliciting public comment on its first draft of revisions.

UCAOA represents more than 6,000 individual members working at more than 2,000 urgent care centers throughout the United States. There are approximately 6,000 urgent care centers currently in the United States making urgent care centers a dominant point of service for health care for millions of Americans. Urgent care centers provide walk-in, extended-hour access for acute illness and injury care that is either beyond the scope or availability of the typical retail clinic or primary care practice. Urgent care centers treat primarily upper respiratory infections, fevers, bronchitis, strains, sprains, minor fractures and lacerations in pediatric, adult and geriatric patient populations. Most urgent care centers offer on-site laboratory, X-ray, electrocardiogram and pharmacy services. Urgent care centers are in position to generate significant cost savings by keeping patients out of costly hospital emergency departments for non-emergent care and to solve physician access issues due to the current shortage of primary care physicians in the United States.

UCAOA asks that, in the final revisions to the Model Act, the NAIC require network plans to include adequate access for their patient populations to after-hours and same-day care for non-life, limb or organ threatening (non-emergency) conditions, including through adequate network access of urgent care centers.
Rationale for Network Adequacy of Urgent Care Centers

A staple of the Affordable Care Act (ACA) is availability of primary care physicians. It is projected there will be a deficit of more than 45,000 primary care physicians by 2020\(^1\), although Americans are already experiencing the effects of an overburdened health care system. Primary care physicians today are providing much less acute care than historically. One of the biggest barriers to acute care in primary care practice is many office-based practitioners’ busy schedules, making same-day scheduling difficult.\(^2\) Same- or next-day access to a provider for insured U.S. adults is low (53 percent).\(^3\) In addition to difficulty obtaining same-day appointments with primary care providers, 57 percent reported difficulty with evening, weekend and holiday care, except for the costly emergency room.\(^4\)

Another study by the Commonwealth Fund found that three in four adults say they have difficulty obtaining timely access to a doctor when medical care is needed. Those surveyed cited difficulty getting same- or next-day doctor appointments when sick, obtaining medical advice from a physician during normal working hours, and getting medical care outside normal business hours (without a visit to an emergency department). As a result of the findings, the Commonwealth Fund and the Dartmouth Institute gathered industry thought leaders who identified six critical areas to increase access to care, including after-hours access and same- and next-day appointments. They concluded that medical homes must provide patients with options for off-hours care, “which can result in a sizeable reduction in emergency room visits.”

Without access to urgent care centers, patients seeking after-hours care will seek care from already overextended and more costly hospital emergency departments. Emergency room crowding is commonplace in virtually every community across the country. A January 2014 report from the American College of Emergency Physicians concluded that access to emergency care in the United States gets a failing grade of D, which reflects too few emergency departments to meet the needs of a growing, aging population, and an increased number of insured due to the ACA.\(^5\)

Section 3: Definitions

While we recognize that that the definition of “facility” under Section 3 (H) is not intended to be exclusive, UCAOA recommends the explicit reference of “urgent care centers” in the definition.

“Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, urgent care centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Section 5: Network Adequacy

Network Sufficiency Standards

The Model Act requires under Section 5 that a network plan shall be sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay and requires access to emergency services 24 hours per day, seven days per week. Given the expectation that health carriers will maintain

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\(^2\) Pitts S, Carrier E. Where Americans Get Acute Care: Increasingly, It’s Not At Their Doctor’s Office. Health Aff September 2010 vol. 29 no. 9 1620-1629 http://content.healthaffairs.org/content/29/9/1620.long


\(^4\) Ibid.

networks that allow covered persons to access providers without unreasonable delay, as well as unfettered access to emergency services, UCAOA recommends that standards for network sufficiency should be expanded to include after-hours and same-day care provided in sites of service, including urgent care centers, other than hospital emergency departments.

UCAOA recommends the following addition to the standards listed at Section 5 (B):

The availability of health care providers to deliver after-hours and same-day care, which may include, but should not be limited to, emergency departments of hospitals.

Access Plan Options
UCAOA appreciates that individual states have different regulatory structures and that revisions to the Model Act are intended to accommodate these differences. UCAOA believes, however, the Model Act should set a rigorous standard for access plan requirements by requiring prior approval by the insurance commissioner of an access plan submitted by a health carrier. Therefore, UCAOA strongly recommends removing “Option 2: Filing of an Access Plan” from the Model Act.

Access Plan Components
UCAOA asks the NAIC to make the following addition and modification to Section 5(F) of the Model Act to ensure consumer access to after-hours and same-day care for non-life, limb or organ threatening (non-emergency) conditions in sites of service other than the emergency department of a hospital:

Add to the list of access plan requirements:

The health carrier’s process for monitoring and assuring on an ongoing basis the sufficiency of the network, including, but not exclusively, emergency departments of hospitals, to meet the need for after-hours and same-day care for non-life, limb or organ threatening conditions.

Modify Section 5(F)(7) to read:

(7) The health carrier’s method of informing covered persons of the plan’s services and features, including but not limited to, the plan’s grievance procedures, its process for choosing and changing providers, its process for updating its provider directories for each of its network plans, a statement of services offered, including those services offered through the preventative care benefit, if applicable, and its procedures for providing and approving emergency, urgent care and specialty care;

Conclusion

UCAOA thanks the NAIC for consideration of its comments. If we may provide any additional information, please contact UCAOA CEO Joanne Ray at (331) 472-3747 or jray@ucaoa.org.

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President
Urgent Care Association of America