January 9, 2015

RE: Health Benefit Plan Network Access and Adequacy Model Act

Submitted via email to: Jolie Matthews (jmatthews@naic.org)

Dear Ms. Matthews:

The Gary and Mary West Health Institute (WHI) is an independent, nonprofit medical research organization that works with healthcare providers and research institutions to create new, more effective ways of delivering care. Established in 2009, with offices in San Diego, CA and Washington, D.C., it is funded by philanthropists Gary and Mary West as part of West Health, four organizations with a common mission—pioneering new and smarter technologies, policies and practices, to make high-quality healthcare more accessible at a lower cost to all Americans.

We are writing to provide feedback on the National Association of Insurance Commissioners’ Health Benefit Plan Network Access and Adequacy Model Act (“draft model”). While the draft model addresses a broad range of network adequacy issues, we will confine our comments to one aspect: the role of telehealth and telemedicine in ensuring access to care.

Specifically, the draft model contemplates “new health care service delivery system options, such as telemedicine or telehealth” as one of the criteria that could be used in assessing the sufficiency of a network.¹ The WHI strongly supports this language and urges its adoption in the final model.

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 130,600 physicians by 2025.² Shortages exist both in primary and specialty care, and are already very significant in some geographies owing to geographic maldistribution (IOM report). At the same time, the need for medical care is ever rising due to a variety of factors from our aging population to our obesity crisis. Simply put: the current model of “in-person” care is not sustainable. Fortunately, technological innovation offers a solution in the form of telemedicine and evolving care models.

In recent years, more and more innovative health care delivery models include some telemedicine option. A recent article in Modern Healthcare discussed the delivery of services as varied as psychiatric care, high-risk pregnancy monitoring, and stroke care via electronic

¹ Section 5B(7).
² See: https://www.aamc.org/advocacy/campaigns_and_coalitions/fixdocshortage/.

Graduate Medical Education That Meets the Nation’s Health Needs (2014)
or telephonic means and estimated that more than half of all U.S. hospitals now use some form of telehealth.³

While these facts are encouraging, a remaining challenge to the growth of telehealth is reimbursement of such services. Although some states have parity laws, not all insurers pay comparable amounts for telehealth services – or even reimburse at all. If left unchallenged, these payment barriers will prevent the full implementation of telehealth as a way to help address workforce shortages in healthcare.

For these reasons, NAIC’s inclusion of telehealth and telemedicine as a criterion for assessing network adequacy is a critical piece of the draft model, and one of which we are strongly supportive. If finalized, NAIC’s draft model will encourage carriers to consider services delivered telephonically or electronically as a way to meet network standards, especially in markets where there may not be a large supply of certain providers. In addition, this formalized acknowledgment by NAIC legitimizes telehealth services in the insurance world – a necessary first step to achieve parity in reimbursement.

For these reasons, we strongly urge adoption of this language in NAIC’s final model. Please do not hesitate to contact me, should you have any questions.

Sincerely,

Nicholas J. Valerian
Chief Executive Officer