Date: January 12, 2015
To: Mr. J.P. Wieske, Chair, National Association of Insurance Commissioners (NAIC) Network Adequacy Model Review (B) Subgroup
Members, NAIC Network Adequacy Model Review (B) Subgroup
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From: Joanne Alig, Senior Vice President, Policy & Research

Subject: Comments on the initial draft of proposed revisions to the Managed Care Plan Network Adequacy Model Act (#74).

The Wisconsin Hospital Association is a statewide nonprofit association with a membership of more than 140 Wisconsin hospital and health systems that includes not only critical access hospitals providing crucial services to their rural communities, but also major academic medical centers providing world-class care, research, and training. On behalf of our members, we are providing comments on the National Association of Insurance Commissioners’ initial draft of proposed revisions to the

The issue of network adequacy has long been of concern and interest to providers in Wisconsin, and as with other states, the implementation of the insurance Exchange marketplace has elevated the issue. The Wisconsin Hospital Association has partnered with the Rural Wisconsin Healthcare Cooperative and has engaged our members in discussions about provider networks. We have been particularly appreciative of the National Association of Insurance Commissioner’s interest in this topic and commend the subgroup for its work on this complex subject.

We respectfully submit the following comments for your consideration as members of the NAIC Network Adequacy Model Review Subgroup.

Section 3 – Definitions – Emergency Medical Condition and Emergency Services

We recommend that the definition of Emergency Medical Condition be no narrower than the definition used in the Emergency Medical Treatment and Labor Act (EMTALA).

The proposed model act requires that an insurer’s health benefit plan provide access to emergency services for emergency medical conditions 24 hours per day, seven days per week. Although not currently included in the model act, some states like Wisconsin through rulemaking require that insurers with defined networks provide coverage for emergency medical conditions by a nonparticipating provider as though the service was provided by a participating provider if the enrollee cannot reasonably reach a participating provider. This is an important protection for the consumer.
EMTALA sets requirements for hospitals to treat a person with an emergency medical condition, and defines emergency medical condition. If the definition of emergency medical condition used for insurance purposes is narrower than the definition set forth by EMTALA, a consumer seeking emergency care at a nonparticipating provider could be treated by the hospital as required by EMTALA, but may not be allowed regulatory protections described above for treatment of medical conditions are considered to be emergency medical conditions under EMTALA. We believe, based on discussion during the subgroup calls, the intent was to harmonize the definitions so that the EMTALA definition is the minimum standard included in the NAIC network adequacy model act.

The definition in the initial draft of proposed revisions to the model act is somewhat narrower than the definition used by EMTALA. The model act defines an emergency medical condition as one that is “sudden, and at the time, unexpected”. EMTALA does not include this language, and we question the need for this additional language in the definition of emergency medical condition. We suggest removing this language.

**Section 5 (E) – Access Plan**

*We recommend that State Insurance Commissioners be required to review a sampling of the access plans submitted by insurance companies both during rate review and after the beginning of the benefit year in order to assess network adequacy by insurers.*

While it is important that insurers file access plans, it is just as important that the insurance commissioner have a process for routinely reviewing the plans. To balance the need for state resources with the need to proactively review network adequacy, WHA recommends the Commissioner review the access plans of a sample of health plans each year. The reviews could be done at the time of rate review, and throughout the benefit year.

Complaints are one means to assess the veracity of the access plan and adequacy of the network; however consumers are often reluctant to complain. Further, while Wisconsin currently allows providers to submit concerns about networks to the Insurance Commissioner’s office, this practice is not well-defined or consistently applied from one Administration to another. We encourage NAIC to include language that would require the Commissioner to implement a process to regularly monitor network adequacy of health plans, and to implement a process for both providers and consumers to register concerns about the adequacy of networks.

**Section 5 and Section 6 F(3) – Criteria for selecting providers**

*We recommend omitting references to selection based on quality of care, and/or clearly specifying that quality standards should not be separately defined by the insurance commissioner, but should be governed by existing health care practices.*

WHA members are committed to high quality high value health care. Wisconsin has one of the most competitive health insurance markets in the country; has maintained a very low uninsured rate for many years; and annually ranks at or near the top nationally in health care quality. WHA supports efforts that recognize and preserve the strengths of our current system while focusing on...
continuing challenges related to health care cost, quality, and coverage in ways that do not jeopardize access.

WHA launched our public reporting initiative, CheckPoint, a decade ago. At that time, the effort represented one of the earliest hospital voluntary reporting programs in the country. Today, over 99 percent of Wisconsin hospitals continue to publicly report performance measures. New measures of meaningful interest to providers, payers and consumers are added regularly. The current initiative remains one of the most robust efforts in the nation that is not the byproduct of state-level or federal-level regulation.

Importantly, there has been significant improvement in almost every clinical and outcomes measure publicly reported by CheckPoint. That success has propelled Wisconsin’s consistently high ranking in the annual Agency for Healthcare Research and Quality (AHRQ) state by state rankings. Even with this success, Wisconsin’s hospital and health system leaders – both in large urban areas of the state and our smaller rural regions - continue to invest in quality improvement. Our response to the initial draft of the model act are based on our significant experience and expertise, and proven results, in voluntary efforts to improve quality.

As NAIC considers the inclusion of quality metrics as it relates to network adequacy, we respectfully suggest that provider quality measurement is not the purview of the insurance commissioner’s office. Nevertheless, should you choose to include some reference to quality metrics, we encourage you to limit the scope of the review to whether an insurer considered quality metrics and not go further in defining quality measures for providers. Significant work is already being done in both the public and private sectors around quality improvement, and we would seek to avoid creating new measures or new requirements that are inconsistent with other ongoing quality improvement efforts. We note in particular that the federal government has recently submitted requirements for quality improvement standards for health plans in the public insurance exchanges; CMS has implemented value based purchasing requirements for hospitals; CMS has also implemented value measurements for physicians. Any strategy must be aligned with existing programs. Creating new measures or imposing similar measures with different definitions would cause confusion for consumers over which standard should be trusted, and may not in effect result in true quality improvement as providers are faced with trying to meet disparate requirements.

We recommend that new data reporting systems should not be created. However, should you choose to include quality references, we encourage you to consider the burden of measurement and reporting on providers and ensure ease of administration. In order to have to comply with quality and data submission standards, there must to be a minimum number of enrollees seeing the provider. If it is too low the data will not be meaningful. There also must be recognition of providers serving specific populations with higher risk. Currently, there is much discussion and consideration when, how, and whether to include socioeconomic factors into quality measurement. No provider should be viewed as having inferior quality simply because the quality metrics have not yet evolved or due to the attributes of the population they serve. We support public reporting of the data that is collected, however this needs to be done in a way as to ensure consistency, accuracy and efficiency for providers, the health plans, and consumers.
Section 7 – Disclosure and Notice Requirements

We recommend omitting the disclosure and notice requirements, and instead carving this subject out for further review and discussion.

The issue of whether and to what extent there are out-of-network practitioners serving patients in an in-network hospital is complex. The draft NAIC model act would require hospitals to provide a notice to patients informing them that a physician or provider within the hospital may not be a practicing provider in the same network as the hospital. Consumer notice is important. However, many hospitals already provide this notice with no appreciable effect on consumer’s understanding of the issue, or on the consumer or hospital’s ability to control which practitioners are available during the consumer’s hospital stay.

Hospitals recognize this not just as a consumer transparency issue, but as a practical concern that can impede their ability to provide care for patients. Rural hospitals in particular often face difficulties with a limited number of practitioners in their areas, and cannot control whether the insurer contracts with every practitioner. Moreover, hospitals are now fielding consumer complaints when a practitioner within the hospital is listed as in-network by the insurer, but is placed by the insurer into a second or third tier of the benefit plan, thus the consumer is charged with a higher copayment or coinsurance.

Patients and providers are the two primary parties in care delivery. Patients and providers are best served when there is sufficient choice of providers, care is easily accessible and there is certainty of when care is being provided in or out of network. Provider networks must be exceptionally clear to consumers so they can make informed decisions at the point of choosing a health plan. Consumers must have the ability to determine which providers are in the network and which are accepting new patients.

First, we recommend that state insurance commissioners work with insurers to ensure that provider directories are accurate and up to date, and include information that allows to consumer to easily determine which providers are included in their specific plan; which providers are included at different tier levels and what the specific cost sharing is for the provider; and information about practitioners and whether the practitioners, such as anesthesiologists, working at in-network hospitals are also in-network.

With respect to the latter, health plan networks often have gaps that result in unexpected expenses for patients. When a health plan contracts with a hospital, not every physician associated with the hospital is included in the network. It is impossible for the hospital to know which practitioners are within network of a specific plan of an insurer, and further which are within a specific tier within a network of a specific plan of an insurer. Only the insurer has the information about which providers and practitioners they have contracted with for specific plans and specific tiers.

Nevertheless, hospitals recognize their role in providing information to patients, and are interested in being proactive partners in finding solutions. Because this topic is complex, we
recommend that this topic be more thoroughly vetted and discussed with health plans, hospitals, other practitioners, and consumer groups.

**New Section– Good Faith Effort to Contract**

We recommend the Act include a requirement that insurers demonstrate a good faith effort to contract with providers before being granted any exception to network adequacy standards.

In its discussions about the Act’s purpose, NAIC subgroup members contemplated whether the scope of the act would extend to contract provisions between providers and insurers. It was suggested at one point that network exceptions may need to rely on a determination of good faith contract.

We appreciate the discussion and the insurance commissioners’ general reluctance to engage in discussions about the adequacy of provider reimbursement. We agree this is not the purview of the insurance department. Nevertheless, within the context of network adequacy, we believe it is important that insurers who request any exception to network adequacy standards demonstrate they have made a good faith effort to contract with providers.

It is understood that from time to time an insurer may require an exception to network adequacy standards. However, such exceptions should be rare and time-limited. An insurer should not be allowed to claim an exception as a regular practice, without demonstrating that a shortage of a provider exists or that they have made a good faith effort to contract with providers.

We recommend as a starting point, language similar to that included in the federal Department of Health and Human Services’ guidance to Qualified Health Plans operating in the Exchange: *To be offered in good faith, a contract should offer terms that willing, similarly-situated providers would accept or have accepted.*

We recognize that implementation of a “good faith” standard would require further discussion and consideration of how such a standard will be monitored and reviewed. We also caution that the role of regulators in monitoring good faith contracts between providers and insurers should be limited to the sole purpose of determining if an insurer claims an exception to the network adequacy standards, and should not be broadened for other purposes. We further recommend that insurance commissioners allow hospitals and other providers to submit complaints when they feel the standard has been breached.

Thank you for the opportunity to comment on the initial draft of the proposed revisions to the *Managed Care Plan Network Adequacy Model Act* (#74). If you have questions or need additional information, please contact me at jalig@wha.org.