

Transmitted via email to jmatthews@naic.org

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J.P. Wieske
Chair, Network Adequacy Model Review (B) Work Group
National Association of Insurance Commissioners
444 North Capitol Street, NW, Suite 701
Washington, DC 20001

Dear Mr. Weiske:

We strongly commend the National Association of Insurance Commissioners (NAIC) for its work in developing model state legislation on network adequacy. The NAIC model contains a number of excellent provisions that appropriately address a range of issues that will help protect the interests of insured patients. However, as hospital-based physician organizations, we are concerned that the current language in the model legislation falls short in its effort to protect those patients from incurring unexpected financial obligations as a direct result of an insurer's failure to maintain an adequate number of hospital-based physicians in its network.

The NAIC in its July 2012 published Whitepaper on Network Adequacy noted that "when developing a network analysis approach, regulatory staff should have a general familiarity with or request information about:

- Hospital-based physicians—such as radiologists, hospitalists, anesthesiologists, pathologists and emergency room physicians—may not be part of the same network as the facility, or may not be in any network. Absence from the network may result in an **inadequate network** for these services. This is particularly the case if the hospital physicians hold an exclusive contract with the facility."¹ [bracketed insertion] (emphasis added)
- "In-depth review of network adequacy should occur at the time a network is established and at least annually. In addition, issuers should be required to submit notification at least quarterly of general changes in their network, as well as prompt notice of a potential loss of a material provider such as a hospital or multi-specialty clinic. An overarching goal of network review is to ensure that the network provides access to the participating providers in order to deliver the services promised under the benefit contract. If such access is not available, then the carrier must make arrangements acceptable to the insurance department or other accountable entity that the services are provided at no greater out-of-pocket expense to the enrollee."²
- "A health carrier's network is never static. In order to ensure it meets the minimum standards for network adequacy on a consistent basis, a carrier must maintain a system for monitoring its network and develop procedures to react to, impending and existent changes in its network that impair adequacy. This would entail a regulatory review of the procedures for monitoring as well as what procedures are in place as to when and how to take corrective action as it applies to its network."³

¹ National Association of Insurance Commissioners (NAIC), *Plan Management Function: Network Adequacy White Paper*, Adopted by the NAIC Health Insurance and Managed Care (B) Committee, June 27 2012, page 4

² NAIC, *Ibid*, Page 5

³ NAIC, *ibid*, Pages 8 & 9

At present, we believe the model does not address the fundamental issues identified by NAIC as it relates to the medical specialties identified as being vulnerable to *de minimis* network standards for adequacy. In addition, it is widely known and accepted that for Qualified Health Plans (QHPs) in the state and federal insurance exchanges payers are now creating “narrow” and “ultra-narrow” networks that are *intentionally* designed to exclude physicians and facilities from plan participation. The result of this intentional design of a benefit plan that is narrowly limited in physician and facility participation will be to create network inadequacy and thereby increased potential for balance billing of enrollees by non-participating physicians. Our suggestions aim to reduce patient financial liability.

Accordingly, we support the recommendation of the Texas Medical Association (TMA) for inclusion of the following modified language in the model legislation:

“A health carrier network shall ensure that for anesthesiology, radiology, pathology, emergency room physicians and hospitalists that there are sufficient numbers of participating physicians at each hospital or facility for the delivery of network services.”

“A health carrier is required to provide notice to covered persons of a substantial decrease in the availability of participating anesthesiologists, hospitalists, radiologists, pathologists, emergency medicine physicians, at a participating facility. A decrease is substantial if the contract between the health carrier and any facility-based physician group that comprises 75 percent or more of the participating physicians for that specialty at the participating facility terminates or the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred physicians for that specialty at the facility terminates. [The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party on request.] The carrier shall prepare an access plan prior to renewing or offering a new managed care plan, and shall update an existing access plan whenever it makes any [material] change to an existing managed care plan. The access plan shall describe or contain at least the following:”

Notably, the language propounded by TMA is currently codified in Texas regulation. In addition, to the TMA language, we support inclusion of the following language:

- 1) In order to ensure adequacy, accessibility and quality, a health carrier must have an ongoing plan for providing network adequacy for its covered persons that includes a process to routinely monitor and assess access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services. The network adequacy plan for these physician specialists shall be consistent with accepted medical standards of care, and any applicable standards issued by the Department, in providing covered persons with timely access and utilization for maintaining quality of care.
- 2) If the department determines that a plan is inadequate for physician specialist services in emergency room care, anesthesiology, hospitalist care, radiology and/or pathology/laboratory services the plan shall be responsible for paying out-of-network physicians the reasonable and customary value for out of network services and at no greater out-of-pocket expense to the patient as would be the case for an in-network physician service. This provision shall not be construed to establish a basis for any implied contract or contract of adhesion between a non-participating physician and a health plan.

We believe that these recommended changes are needed to statutorily empower and direct state insurance departments to protect the interests of insured patients in need of hospital-based services by ensuring that health plans provide sufficient access to and coverage for hospital-based physicians. Failure to adopt these recommendations could easily result in the absence of too many hospital-based physicians from health plan networks, resulting in the inadequate network scenario that the NAIC described in its 2012 white paper. Moreover, we believe that in cases of health plan inadequacy, as determined by the state, the patient should be held harmless by the health plan, apart from the patient's in-network costs (co-pays, co-insurance, and deductibles) that would be incurred had the services been rendered in-network. Accordingly, the health plan should be financially responsible for payment of all physician billed charges.

We believe that these two provisions will incentivize health plans to operate and maintain network adequacy for these physician services. Moreover, we do not support efforts that, through law or regulation, seek to construct contracts between insurers and physicians where no such contract actually exists. Such laws establish contracts of adhesion and reward insurers who do not undertake the necessary investment to create an adequate network.

Thank you for your consideration of these recommendations.

Sincerely,

Members of the Hospital Based Physicians Caucus of the American Medical Association

- American College of Emergency Physicians
- American College of Radiology
- American Society of Anesthesiologists
- College of American Pathologists
- Society of Hospital Medicine