



**American Hospital
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January 12, 2015

J.P. Wieske
Wisconsin Office of the Commissioner of Insurance
Chair, NAIC Network Adequacy Model Review (B) Subgroup
National Association of Insurance Commissioners
444 North Capitol Street, N.W., Suite 701
Washington, DC 20001

Jolie H. Matthews
Senior Health and Life Policy Counsel
National Association of Insurance Commissioners
Hall of States, Suite 701
444 North Capitol Street, N.W.
Washington, DC 20001-1509

***RE: Recommendations for Updates to the NAIC Managed Care Plan Network
Adequacy Model Act of 1996***

Dear Mr. Wieske and Ms. Matthews:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide comments to the National Association of Insurance Commissioners' (NAIC) Subgroup regarding updates to NAIC's 1996 Managed Care Plan Network Adequacy Model Act (Model Act). Network adequacy is a significant issue for patients and providers, and the AHA thanks you and the Subgroup for the many opportunities to participate in your deliberative process.

In addition to our attached detailed recommendations, this letter presents our overarching comments regarding the draft Model Act. The AHA strongly believes that patients and providers, the primary parties involved in care delivery, are best served when: 1) there is sufficient choice of providers; 2) care is easily accessible; and 3) patients and providers are certain of when care is being provided in or out of network and clearly understand their financial obligations under either scenario. Patients and their families should be protected, to the extent possible, from the financial burdens of unexpected balance billing. The AHA believes it is important to ensure that health plan enrollees have access to a selection of high-quality providers in or near their communities, while not inhibiting care coordination and the growth of integrated care systems. Integrated care systems, by



their nature, offer smaller networks of providers. However, those providers are highly integrated, coordinate multiple aspects of care delivery in a defined geographic area and use a common electronic health record.

With regards to the language of the Model Act, the AHA believes there should be greater focus placed on the obligations of health carriers to ensure adequate networks rather than on the contractual relationships between health plan carriers and providers. The AHA recommends that the Model Act emphasize the need for oversight of health insurance carriers to ensure that their networks are providing the promised health care services and benefits to their enrollees. The Model Act, as currently drafted, relies too heavily on the provider as the backstop to ensuring adequate networks.

The remainder of this letter focuses on three key areas that need to be addressed in the current draft of the Model Act in order to ensure appropriate responsibilities are clearly attributed to the health plans: balance billing; who stands as guarantor of insurance coverage; and provider obligations when a contract is terminated. Additional areas of considerable importance to the AHA, such as addressing tiered networks, specific network adequacy criteria, formal approval by regulators of each carrier's access plans, and requirements for clear communications of network composition, are addressed in detail in the attachment.

BALANCE BILLING

Consumers are at greater risk for higher out-of-pocket costs when health plans do not synchronize their network contractual relationships with physicians and the hospitals at which they practice. Unexpected balance billing of patients following a medical procedure continues to be an area of concern for the AHA, patients and patient advocates, and other stakeholders. At issue is when the hospital and the admitting physicians or surgeons are both in network, but other hospital-based physicians providing care are not. While some patients may choose to receive services out of network, and expect to be balance billed for these services, others are at risk for unplanned out-of-pocket costs when hospital-based physicians, such as an emergency department physician, anesthesiologist, radiologist or pathologist, do not participate in the same networks as the hospital, attending physician or surgeon providing services at that hospital. This occurs sometimes because a plan will not negotiate network contracts with hospital-based physicians, or a physician may choose not to contract with the plan, or may not accept an offer of employment from the hospital. Due to these circumstances, there are typically at least a few out-of-network physicians practicing at the majority of hospitals.

Consumers typically are not aware of the identity or network status of hospital-based physicians who may provide services to them while they are an inpatient. The nature of these services and the need to provide 24/7 availability is such that it is impossible to know with certainty which hospital-based physician may provide services to any given patient at any given time. For example, one surgery that lasts longer than expected can cause a last-minute change in the anesthesiologist for a second surgery. Illness or other emergencies can cause similar last-minute substitutions. When any of these

circumstances occur, the patient can end up receiving care from an out-of-network physician, resulting in a surprise bill from that physician.

Some stakeholders have suggested that the Model Act should require in-network hospitals to either provide specific estimates of services provided in their facility by out-of-network physicians or prohibit any balance billing by hospital-based physicians who are not in network. This is not feasible from a practical perspective since these physicians, while based in the hospital, are not employed or under contract with the hospital, and the hospital has no bearing on their rates or their contracting and billing practices. Further, this solution would inappropriately shift the burden of ensuring the adequacy of the network away from the health plan carrier to the hospital.

Health plans, rather than providers, are accountable for ensuring network adequacy and informing their members of which physicians are in-network and what an enrollee's financial responsibility may be for an episode of care. The AHA continues to recommend that, while health plans bear the ultimate responsibility for network adequacy and communication, providers and other parties should play a role in protecting consumers from unexpected balance billing. Below are some roles we believe stakeholders should play:

- Health Plans. Health plan carriers should be required to disclose which physicians, medical groups and hospitals are in-network. Plans have an obligation to explain the financial implications of using out-of-network providers and provide the consumer/enrollee with reasonable cost estimates. Such information should be easily accessible to the consumer through online and other consumer-assisted tools, such as call centers.
- Physicians. Admitting physicians and surgeons are obligated to inform plan enrollees if they are out-of-network for that enrollee's plan when they recommend hospital care. If an in-network physician or other in-network provider is coordinating the care of an enrollee, that physician or other provider has an obligation to inform the enrollee if the providers to whom he or she is being referred are in the enrollee's plan network. Unfortunately, these solutions are not practical in some care settings, such as during surgeries.
- Hospitals. For non-emergency services, hospitals should make information available, to the extent practicable, to plan enrollees, or explain how to get timely information from their health plan about whether hospital-based physicians participate in their plan's network. Where all of the hospital-based physicians are employees or in-network physicians, there is not an issue. Where hospital-based physicians are a mixture of in-network and out-of-network physicians, it is virtually impossible to know which physician might provide services at any given point in time. Hospitals are not a party to contracts between health plans and independent physicians. But hospitals can and should provide, to the extent

practicable, an explanation of the financial implications when receiving services from an out-of-network physician or other provider.

GUARANTOR OF INSURANCE COVERAGE

As currently written in the Model Act, the required provision in contracts between health plans and providers stipulates that, when a health plan or intermediary becomes insolvent or otherwise ceases to operate, network providers must continue to provide covered services to any covered person who at that time is receiving inpatient care, until that person no longer requires that inpatient care. Other provisions in that section make it clear that this obligation has no other end point. It extends beyond the demise of the intermediary or carrier, the end of premium payments, the termination of the provider contract, and the end of the state's responsibility to cover claims under guarantee funds. In other words, everyone's obligation has an endpoint except the provider. As such, health care providers are compelled to act as guarantors for health plans and, in essence, to accept insurance risk and provide insurance coverage to these persons without an insurance license.

The AHA's recommended language changes make the distinction between a provider's obligation to continue providing care and any suggestion that the provider is a guarantor of insurance coverage.

PROVIDER OBLIGATION IN CONTRACT TERMINATIONS

The AHA believes that health plans have an obligation to continue to reimburse providers in the case of a contract termination when that provider is engaged in medically necessary treatment for the enrollee at the time of termination of the contract. The AHA, however, does not agree with the provision that would allow state insurance departments to dictate the payment rate between health carriers and providers once the contract is terminated. The payment rate should be negotiated between the carrier and provider.

The AHA continues to encourage NAIC to align the Model Act with the network adequacy provisions of the Affordable Care Act (ACA) and the regulations implementing the ACA to ensure greater consistency in the general insurance marketplace. In addition, the AHA encourages NAIC to update the Model Act to address issues arising from new forms of plans in the market and to ensure consistency with Medicaid managed care laws and requirements. Finally, the AHA encourages NAIC to develop model regulation in addition to model legislative language to ensure greater consistency across states as they develop laws, rules and policies to govern adequate provider networks. NAIC plays an important role in developing guidance that reflects the dynamic insurance marketplace while also balancing protections for all stakeholders, in particular the consumer.

Mr. Wieske and Ms. Matthews

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We look forward to the subgroup's continued discussion of this and related issues. If you have any questions about this proposed revision, please contact me at (202) 626-4639 or jgoldman@aha.org, Ellen Pryga, AHA policy director, at (202) 626-2267 or epryga@aha.org, or Molly Collins Offner, AHA policy director, at (202) 626-2324 or mcollins@aha.org.

Sincerely,

/s/

Jeffrey Goldman
Vice President, Coverage Policy

Attachment: AHA Comments to NAIC 11/12/14 Draft Model #74