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Executive Director

January 12, 2015

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Mr. J.P. Wieske
Wisconsin Office of the Commissioner of Insurance
Chair, NAIC Regulatory Framework (B) Task Force
c/o National Association of Insurance Commissioners (NAIC)
701 Hall of the States Building
444 North Capitol Street, N.W.
Washington, D.C. 20001-1509

ATTN: Jolie Matthews, Senior Health and Life Policy Counsel

Dear Mr. Wieske, Ms. Matthews, and Regulatory Framework (B)
Task Force Members:

Thank you for opportunity to comment on the November 12, 2014 draft revisions to the NAIC's Managed Care Plan Network Adequacy Model Act. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level. NHeLP has written extensively about the importance of network adequacy, particularly regarding low-income consumers.¹ We recently provided detailed comments on network adequacy in the Exchanges to the U.S. Department of Health and Human Services in our comments to the November 2014 Proposed Notice of Benefits and Payment Parameters regulations.² Last spring we

¹ See, e.g., NHELP, NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA PLANS (2014), available at <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/network-adequacy-laws-in-covered-california-plans-issue-No-2>; NHELP, MEDICAID MANAGED CARE MODEL PROVISIONS: NETWORK ADEQUACY (2014), available at <http://www.healthlaw.org/publications/browse-all-publications/medicaid-managed-Care-model-provisions-issue-3>; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), available at <http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicaid-managed-care>.

² Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Centers for Medicare & Medicaid Servs., Dept. of Health & Human Servs. 28-53 (Dec. 22, 2014), available at

also provided comments to the Centers for Medicare and Medicaid Services recommending improvements in network adequacy requirements for Medicaid Managed Care plans.³

Drawing on this experience and expertise, NHeLP commends the Task Force for undertaking revision of the Model Act this year. Network adequacy protections are critical in making the promise of health care real for consumers. Updates to the Model Act are urgently needed to reflect the requirements of the Affordable Care Act (ACA), to account for changes in health carriers' approaches to networks since 1996, and to ensure that the plans consumers purchase offer them adequate coverage. We commend the changes that the Task Force has proposed, many of which will provide consumers with significant protections to ensure they have access to the health care services they need. In particular:

- We strongly support the addition to section 5(A) that would require plans to make all covered services available through network providers at the lowest cost-sharing tier without undue travel or delay;
- We support the addition to section 6(L)(2) that would require plans to provide continuity of care for certain enrollees when their providers leave the plan; and
- We support the addition of section 7(A) to ensure that provider directories are accurate and up-to-date.

NHeLP strongly supports the revisions to the Model Law suggested by the NAIC Consumer Representatives, and we urge the Regulatory Framework (B) Task Force to adopt those revisions. We have submitted our complete suggestions in track changes to the attached document; our edits incorporate and build off of those of the Consumer Representatives. We offer the following highlights of our recommendations for updating and strengthening the Model Act:

- **Adopt specific minimum standards for time and distance access.**

We join the Consumer Representatives in strongly urging the Task Force to strengthen the requirements of section 5(B) to require carriers to meet minimum time and distance standards. National programs including TRICARE and Medicare Advantage already employ such standards. We appreciate that states will require a certain amount of

<http://www.healthlaw.org/publications/browse-all-publications/nhelp-comments-notice-of-benefit-and-payment-parameters>.

³ See *generally* NHeLP, HEALTH ADVOCATE: MEDICAID MANAGED CARE: MODERNIZED FEDERAL REGULATIONS ARE LONG OVERDUE 1-3 (2014) (summarizing recommendations and citing to detailed proposed regulatory provisions), *available at* <http://www.healthlaw.org/issues/medicaid/managed-care/Health-Advocate-Sept-2014>.

flexibility to meet the unique needs of their state, but we believe that NAIC could play an important role in establishing a minimum, quantitative standard for states' consideration. We particularly recommend that the Task Force consider California's time and distance standards, which have generally been successful in protecting access to care in that state, notwithstanding its large size and geographic diversity. See Cal. Code Regs, tit. 28, §§ 1300.51(c)(H) (distance), 1300.67.2.2 (time).

- **Require that quantitative measures of types and numbers of providers is measurably tied to actual availability of covered services**

Measuring types and numbers of providers is critical but not sufficient in assessing the adequacy of a plan network. Additional criteria such as whether network providers are accepting new patients and whether providers actually offer covered services (this is particularly important with respect to reproductive health services) should be required measures in determinations of adequacy.

- **Require carriers to account for language accessibility of their networks.**

Because many limited English proficient (LEP) individuals enroll in health plans in the United States, we urge the Task Force to flag for states that they should consider linguistic access in evaluating the sufficiency of their plans' networks. Ideally, health carriers should collect and report data on the languages spoken by participating providers and facilities, and this information should be matched with state demographic information about the languages spoken by LEP individuals in the plan's service area, to ensure that services are accessible to LEP individuals. We also suggest NAIC specifically include the need for insurers to comply with Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act to the extent these laws apply to them.

We suggest that the NAIC include a drafting note, noting that states may require carriers to ensure that any provider counted as speaking a non-English language have sufficient language competency in that language, which could be determined by testing. Effective communication depends on actual language proficiency and competency. If a member of the provider's staff has the language competency and is going to interpret for the patient and provider, the staff person must have sufficient knowledge, skills and training as an interpreter. The drafting note could also recommend that carriers designate who in the provider's office—the provider or his/her staff—could provide services directly in the non-English language and serve as interpreters.

- **Ensure that carriers account for accessibility of their networks to enrollees with disabilities.**

Health plans serve individuals with physical, developmental, and mental disabilities. The Task Force should note in the Model Act that health carriers have an obligation to account for the needs of enrollees with disabilities in designing their networks and complying with applicable federal civil rights laws. Carriers must ensure that they offer network providers and facilities that are physically and programmatically accessible to their enrollees.

- **Mandate carriers to account for instances where providers may refuse to provide services due to religious or moral objections.**

Currently, the Model Act does not appear to account for situations where a provider refuses to provide a covered service otherwise within his or her practice area, or when a facility refuses to allow willing providers to provide covered services on its premises. Many states explicitly permit providers to refuse to provide services due to religious or moral objections. These provider refusals can particularly limit access to covered reproductive health services. For example, even if a carrier contracts with many OB/GYNs, if none of them prescribe contraception, provide abortions, offer family planning counseling, or make referrals for those services, enrollees do not have real access to these services. We urge the Task Force to amend the Model Act to account for provider refusals. Additionally, each plan that requires a referral for certain reproductive health services should have in place a clear and transparent process for overriding a primary care physician's refusal to make a referral. Last, health plans should be required to notify enrollees that some providers may refuse to provide covered services, and include a toll-free number or online resource that allows enrollees to determine which providers offer services they need. See California Health & Safety Code § 1363.02.

- **Broaden the new transitional care protections to ensure continuity of care for new enrollees, and extend the amount of transitional coverage.**

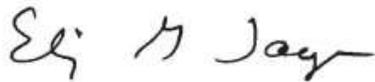
Finally, as we mentioned above, NHeLP strongly supports the new provisions in the Model Act that would require carriers to provide transition coverage when an enrollee's provider leaves the network for a reason other than termination for cause. These protections are crucial to ensuring that enrollees are not forced to switch providers at a crucial point in their care—for example, right before labor for a pregnant woman, or in the middle of cancer treatment. But these transitional situations do not only arise when an enrollee's provider leaves the plan. More and more, they arise when consumers are

forced to switch to a new plan due to circumstances outside of their control—for example, because they have lost their job, or because a change in family income moves them from Medicaid to the Exchange. We strongly urge the Task Force to amend the Model Act to provide for transitional coverage upon enrollment in a new plan.

Moreover, for all enrollees who need transitional coverage, we urge the Task Force to lengthen the amount of coverage that is required. For many, ninety days will not be sufficient time to make an adequate transition to a new provider and ensure continuity of care. In particular we join the Consumer Representatives in urging that for pregnant enrollees, carriers be required to continue care with out-of-network providers through the postpartum period; and for enrollees with a terminal illness, carriers be required to continue care until death. In all other cases, we suggest that carriers continue care for the duration of treatment or up to one year.

Thank you again for the opportunity to review the Model Act. If you have any questions or need any further information, please contact Abbi Coursolle (coursolle@healthlaw.org; 310-736-1652), Staff Attorney, at the National Health Law Program.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive, flowing style.

Elizabeth G. Taylor
Executive Director