AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Ted Nickel
Commissioner
Wisconsin Office of the Commissioner
of Insurance
PO Box 7873
Madison, WI 53707-7873

The Honorable Todd E. Kiser
Commissioner
Utah Insurance Department
3110 State Office Bldg.
Salt Lake City, UT 84114-1201

Re: AMA Comments on Draft NAIC Network Adequacy Model Bill

Dear Commissioners Nickel and Kiser:

On behalf of our physician and student members, the American Medical Association (AMA) appreciates the opportunity to continue our involvement in the revision of the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act (the draft model act).

On several important fronts, the draft model act improves upon the 1996 version and includes stronger regulatory requirements to improve transparency and access to care. In particular, we are pleased that provisions requiring stronger regulation and transparency of provider directories; a shift away from using accreditation as a "deeming" tool; a focus on access to appropriate specialty care, including pediatric specialty care; and transparency in carriers' selection standards have been included in the draft model act.

However, we continue to have concerns with several aspects of the draft model act. As you evaluate the current draft model act, we ask that you adopt the amendments outlined below to encourage strong networks and meaningful access to care, and to better ready the model act for consideration by individual state legislatures.

Effectively and fairly addressing out-of-network billing

The AMA suggests that Section 7, while attempting to protect consumers from unanticipated out-of-pocket costs, will have the negative impact of discouraging insurers from contracting with health care professionals — perpetuating the network issues that promoted the revisions to this model in the first place. We believe that the issue of so-called "surprise" billing should be addressed through strong quantitative standards that specifically require regulators to evaluate access to participating health care professionals at participating hospitals in each network. A network that does not provide adequate access.

to in-network care at contracted hospitals should simply not be sold to consumers. The AMA maintains that this lack of alignment in networks is the root cause of surprise billing issues and is inadequately addressed in this model.

However, should the Task Force choose to include Section 7 in the model act moving forward, the AMA respectfully suggests additional edits to lessen the negative impact this proposal might have on state markets and to help clarify the rights and responsibilities of impacted parties.

First and foremost, the AMA strongly encourages the Task Force to adopt a fair payment standard based on independent, out-of-network charge data. The current payment standard outlined in the draft model act would set payments to health care professionals at a percentage of Medicare or the discounted in-network rate. Neither of these benchmarks represents the cost of providing care and adoption would so significantly skew contract negotiations in favor of insurers that health care professionals who practice in hospitals would be unable to negotiate fair contracts. Please understand that we are not suggesting that physicians should be able to collect excessive or unfair fees for their services, and the AMA has strong policy opposing unethical billing practices. Instead, we are suggesting that in a world where the large insurers are merging and provider networks are narrowing, physicians need some leverage to negotiate a fair contract. A payment standard that falls below market rates and is not based on independent, out-of-network charge data will result in a market that cannot work for physicians, and in-turn patients.

In addition to a fair payment standard, the AMA asks that the Task Force clarify that this section applies only to unanticipated out-of-network charges for services received at participating facilities. We also ask that the language clarify that, if the billed charges are within the range disclosed and agreed to by the patient prior to care, or if the bill is $500 or less, the patient's bill no longer falls within the purview of this section. These changes would help clarify the complicated process outlined in this section.

Appropriate use of telemedicine

During drafting discussions with the NAIC Network Adequacy Subgroup, the AMA and others were told that the regulators did not intend for telemedicine to be used as a replacement for in-network providers for the purposes of determining network adequacy. However, the language contained in Section 5(F)(1) implies otherwise.

The AMA strongly believes in the promise of telemedicine and is working hard to streamline the adoption of telemedicine in the states by proposing changes to state laws and regulations that may restrict these new ways of delivering care. However, we do not believe it is in the best interest of consumers to allow telemedical providers to supplant in-person providers for the purposes of network design, and that networks should provide adequate access to in-person providers whenever possible. Therefore, we suggest clarifying the Network Adequacy Subgroup's intent by changing the language in Section 5(F)(1) to simply and clearly state that the access plan shall describe or contain "the health carrier's network, including how the use of telemedicine or telehealth or other technology may be used."

Prior approval of networks

While the current draft model act takes important steps toward increasing regulator oversight of networks to ensure access to care, the AMA believes a critical requirement is still missing. The draft model act, as currently written, provides legislatures the option of either requiring regulator approval of networks before they go to market *or* allowing the networks to be reviewed at some point, once they are already being sold to consumers.

The AMA does not believe that the more passive review option is sufficient and instead suggests that active, prior approval of networks is a critical function of regulating networks and ensuring that patients purchase products that will provide access to all covered services before it is too late. Additionally, it is equally important that the network be re-approved by regulators before material changes are made to the network to protect patients who might otherwise find themselves stuck in a network that no longer offers them access to needed care. The AMA respectfully asks that the Task Force clarify that prior approval of networks is the only appropriate option.

Establishment of quantitative standards

The AMA strongly supports the use of quantitative standards to measure networks adequacy. The draft model act outlines several types of quantitative measurements that may be used, while allowing regulators to adopt specific thresholds reasonable for their state. But unfortunately, again, the current draft model act provides these measures as an option for states, rather than a requirement.

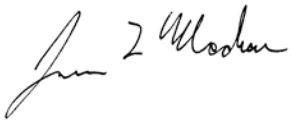
The AMA asks that the draft model act be modified to assert that a state should adopt quantitative standards to determine network adequacy. Encouraging states to establish a clear set of numeric quantitative standards is necessary to assure a consistent benchmark for regulators and an objective standard upon which insurers can design on their network. Without such clarity, the subjective measurement that is the status quo will continue to the detriment of patients.

Regulation of tiered networks

The AMA continues to be concerned that tiered networks, as defined under the current draft model act, may be designed in discriminatory ways, and result in cost-shifting onto patients for covered services. For example, physicians that provide care to patients with complex health care needs are often placed in a high cost-sharing tier, so these patients pay much more out-of-pocket to simply access their physicians. Moreover, tiered networks as a whole may have a sufficient number of providers, but when examined more closely, access to physicians at an affordable tier is limited. As such, we ask that the Task Force establish a requirement in the draft model act that tiered networks meet all network adequacy requirements with the lowest-cost sharing tier.

As you move forward with the draft model act, we thank you for your consideration of our concerns. Please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center at (312) 464-4954 or daniel.blaney-koen@ama-assn.org, or Emily Carroll, JD, Senior Legislative Attorney, Advocacy Resource Center at (312) 464-4967 or emily.carroll@ama-assn.org with any questions.

Sincerely,



James L. Madara, MD

cc: Members of the NAIC Regulatory Framework Task force
Jolie Matthews
J.P. Wieske