

January 12, 2015

Mr. J.P. Weiske
Chair, Network Adequacy Model Review (B) Subgroup
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Ms. Jolie H. Matthews
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Re: NAIC Managed Care Network Adequacy Model Act

Dear Mr. Weiske and Ms. Matthews:

On behalf of the American Society of Retina Specialists (ASRS), we thank the National Association of Insurance Commissioners (NAIC) for undertaking the important task of updating the NAIC's Managed Care Network Adequacy Model Act and for soliciting public comment on its first draft of revisions. The ASRS is the largest retinal organization in the world, representing nearly 2700 board certified ophthalmologists who have completed fellowship training in the medical and surgical treatment of retinal diseases.

With the understanding that the NAIC's goal is adoption of a revised Managed Care Network Adequacy Model Act by a majority of states, ASRS appreciates that in making revisions to the Model Act, the Network Adequacy Model Review Subgroup sought to balance the interests of insurers, health care providers, and consumers, as well as the diversity of states and their regulatory structures. We agree that the old model does not reflect the current insurance market, thereby necessitating revisions. ASRS supports the draft revisions but recommends additional modifications to ensure that consumers have timely access to highly subspecialized physicians, including retina specialists. The following are our suggestions to make the Model Act more comprehensive in protecting the array of stakeholders.

Section 3: Definitions

The narrowing of plan networks has become increasingly problematic for patients requiring highly subspecialized care, including patients with retinal diseases who require care by retina specialists. With the increasing subspecialization of medicine, we believe carriers may appear to demonstrate network adequacy at the specialty designation level, but still lack in-network physicians or access to out-of-

network physicians with specialty expertise or experience in certain complex, rare, or hard-to-treat diseases. ASRS does not believe it is adequate for health carriers to assess network adequacy of specialists based on the number of providers in a network with certain specialty designation codes, which we believe is the practice typical of most health carriers. Therefore, ASRS firmly believes “specialty” and “subspecialty” must be specifically defined in the Model Act.

ASRS recommends the definitions of specialty, subspecialty, board certification, and physician in the Model Act to read as follows:

“Specialty provider” means a physician who has successfully completed a residency or fellowship training program which is accredited by the Accreditation Council of Graduate Medical Education, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

“Subspecialty provider” means a physician whose scope of residency or fellowship training encompasses the treatments, conditions, or procedures for which subspecialization is being claimed.

“Board certification” means either

- (i) certification by a member board of the American Board of Medical Specialties or the American Osteopathic Association; or**
- (ii) Requisite successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education or the American Osteopathic Association that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the American Board of Medical Specialties or American Osteopathic Association board for that training field and further successful completion of examination in the specialty or subspecialty certified.**

“Physician” means licensed medical doctor or doctor of osteopathy.

To best assure network adequacy of subspecialty providers, ASRS recommends that in all instances of the Model Act where “specialty” is referenced, “subspecialty” should be added.

Section 4: Applicability and Scope

ASRS supports the revised drafting note regarding accreditation. Specifically, the “drafting note” in this section is revised to state “accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an additional regulatory tool in determining compliance with the standards required under this Act.”

Section 5: Network Adequacy

Provider-Covered Person Ratios

For determining whether a health carrier providing a network plan has sufficient numbers and types of providers, the Model Act articulates eight criteria for determining “sufficiency,” including “Provider-covered person ratios by specialty.” ASRS recommends adding a “drafting note” to ensure that all provider-covered person ratios account for part-time providers or those who practice at multiple locations.

Access Plan Options

As previously stated, ASRS appreciates the proposed revisions to the Model Act recognizing that individual states have different regulatory structures. However, ASRS believes the Model Act should set a more rigorous standard for access plan requirements by requiring prior approval by the insurance commissioner of an access plan submitted by a health carrier. Therefore, ASRS strongly recommends removing “Option 2: Filing of an Access Plan” from the Model Act.

Access Plan Components

ASRS believes it is important to understand how health carriers are assessing adequacy of specialty and subspecialty providers.

ASRS asks the NAIC to consider the following addition to Section 5(F) of the Model Act to ensure consumer access to specialty and subspecialty providers:

F. The access plan shall describe or contain at least the following:

The health carrier’s methods for assessing and monitoring, on an on-going basis, the sufficiency of specialty and subspecialty providers (including those without Medicare and other payer-recognized specialty designation) in the plan network to meet the health care needs of populations that enroll in managed care network plans;

Many subspecialists, like retina specialists, do not have a specialty designation recognized by Medicare and other payers. Consequently, these subspecialists may not be considered when a plan is compiling its network or being assessed for network adequacy. For example, a health carrier may attest to an adequate number of ophthalmologists, but not have any or an inadequate number of retina specialists. As a result, patients may be required to seek highly specialized care from network physicians who lack specialty expertise or experience in the management of certain diseases.

Therefore, ASRS asks the NAIC to add the following “drafting note” to the Model Act:

Drafting Note: States may want to consider requiring a health carrier assess and monitor the sufficiency of specialty and subspecialty providers by reviewing claims history and maintaining a panel of physicians who have historically billed for covered specialty services.

Section 6: Requirements for Health Carriers and Participating Providers

ASRS appreciates the revisions to Section 6 (F) regarding standards for selecting or tiering of participating providers. However, we believe further revisions are necessary to ensure that subspecialty providers are not unfairly compared to their specialty peers where the mix of services provided may not lend to adequate comparisons of quality and resource use. For example, since only retina specialists have appropriate training to perform procedures such as pars plana vitrectomy, scleral buckling, and posterior segment trauma repair, as well as to manage many complex conditions including diabetic macular edema and age-related macular degeneration, they should not be compared to general ophthalmologists.

Therefore, ASRS recommends at Section 6 (F)(3) the following addition:

(3) Selection criteria shall not be established in a manner:

That fails to use appropriate peer comparisons, including at the specialty and subspecialty levels of services provided and billed, when assessing individual provider quality and resource use.

At Section 6 (G), ASRS recommends the following revision:

G. A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for review and approval by the commissioner and subsequently make those standards available to providers and consumers.

We believe it is important for these standards to be made available to providers due to the current lack of transparency by health carriers in making decisions about provider tiering.

ASRS is also very concerned about the practice of health plans dropping providers, namely physician specialists and subspecialists, from their networks during the middle of the plan year without cause. “Mid-year” terminations, as well as reassigning providers mid-year to tiers with higher consumer cost-sharing requirements, can carry, as the Model Act suggests, negative patient continuity of care and financial implications. ASRS recommends that in Section (6), the following requirement be added:

A health carrier may not remove a provider of services from a network plan during the middle of a policy or contract year unless the carrier has cause to remove such provider.

We also recommend including a drafting note providing examples of what may be considered “cause” for removal, such as loss of licensure or conviction of fraud and/or abuse, as well as what may not be considered “cause” for removal, such as provider economic profiling and provider choice of drug/therapy.

Additionally, at Section 6 (L)(b), ASRS recommends the following modification:

The health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all covered persons who are patients seen within the past year (or as long as the patient has been with the health carrier, whichever is shorter) ~~on a regular basis~~ by the provider, whose contract is terminating, irrespective of whether the termination was for cause or without cause.

Section 8: Provider Directories

ASRS applauds NAIC for the addition of this section given the growing number of complaints by consumers and providers about inaccurate provider directories. A Nov. 25, 2014 *Wall Street Journal* article highlighted situations in which physicians dropped from networks are still listed in provider directories for 2015. In other situations, a provider may be listed as in-network in a provider directory, but the “in-network” status may be limited to certain facilities with which the carrier has a contract, consequently providing misleading or confusing information to the consumer.

ASRS believes additional modifications should be made to the Model Act to make directories even more comprehensive, thereby allowing consumers to make informed decisions about their health plan and effectively manage their care. ASRS recommends that provider directories also include the following information:

- Provider specialty *and* subspecialty;
- Location(s) where the health care professional has regular, repeating office hours (e.g., practices for greater than or equal to 25 percent of their time);
- Applicable contact information for *each* practice location; and
- Days the actual health care professional typically practices at referenced location(s), independent of the hours that a physician assistant or other non-physician provider is on hand.

Additionally, we believe the Model Act should *require*, rather than suggest in a drafting note, that health carriers verify the accuracy of their directories and detail the methods by which that verification occurs. Without requirements of verification, we are concerned that the proposed provider directory requirements will not vastly improve directory accuracy.

Conclusion

ASRS thanks the NAIC for consideration of its comments. If we may provide any additional information, please contact Jill Blim, ASRS Executive Vice President at jill.blim@asrs.org.

Sincerely,



Tarek S. Hassan, MD
President