



## AMERICA'S ESSENTIAL HOSPITALS

January 12, 2015

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Washington, DC 20001

**Ref: Draft Health Benefit Plan Network Access and Adequacy Model Act**

Dear Ms. Matthews,

Thank you for the opportunity to submit comments on the National Association of Insurance Commissioners' (NAIC's) draft Health Benefit Plan Network Access and Adequacy Model Act. America's Essential Hospitals appreciates the work of the network adequacy model review subgroup to update the Managed Care Network Adequacy Model Act so it applies to a broader range of health plans, including qualified health plans (QHPs) offered through the health insurance marketplaces (exchanges).

The health insurance landscape continues to change, as the marketplaces begin their second year and other Affordable Care Act (ACA) coverage expansion provisions are implemented. As a result, revisions to the model act are imperative to ensure health plan networks do not exclude crucial providers and leave patients without access to a range of vital services. The work of the subgroup is a step in this direction. However, America's Essential Hospitals remains concerned that the network adequacy provisions and the requirements for including essential community providers (ECPs) in plan networks are lacking and may leave many of the nation's most vulnerable patients unable to access the providers on which they rely.

America's Essential Hospitals is the leading association and champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Filling a vital role in their communities, our more than 250 member hospitals are ECPs shouldering a disproportionate share of the nation's uncompensated care and devoting more than half of their inpatient and

outpatient care to Medicaid or uninsured patients. A majority of patients at essential hospitals are racial and ethnic minorities, many of whom rely on the culturally and linguistically competent care that only essential hospitals are able to provide. Our members provide this care while operating on margins substantially lower than the rest of the hospital industry—with an aggregate operating margin of -0.4 percent, compared to 6.5 percent for all hospitals nationwide.<sup>1</sup>

As ECPs, our members provide a continuum of primary through quaternary care, including trauma care, burn care, and public health and wraparound services such as translation, transportation, health fairs, health screenings, and other types of community outreach. They also deliver ambulatory care services to schools and housing developments through mobile units, many of which offer onsite behavioral health support services, interpreters, and patient advocates who can access medical and social support programs. Many of the patients served by essential hospitals have developed longstanding relationships with these providers and rely on the array of specialized services and culturally competent care they alone offer.

Many of our hospitals' patients have gained coverage for the first time through the marketplaces, and many may transition into and out of marketplace coverage over time. Thus, including ECPs in QHP networks is critical to maintaining patients' access to services and continuity of care as their coverage status changes. Because these low-income patients are generally not as healthy and receive less preventative care and recommended screenings as those with private coverage,<sup>2</sup> they have come to rely on the inpatient, ambulatory, specialty, and critical care services our members provide.

**As NAIC continues to refine the provisions of the model act, we ask the organization to consider the following comments.**

1. NAIC should strengthen network adequacy provisions in the model act to ensure vulnerable patients have access to a comprehensive range of vital services from essential providers.

**NAIC should add language to the model act that requires insurance carriers to establish and maintain adequate provider networks. These networks**

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<sup>1</sup>Reid K, Roberson B, Laycox S, Linson M. Essential Hospitals Vital Data: Results of America's Essential Hospitals Annual Characteristics Survey, FY 2012. America's Essential Hospitals. July 2014. <http://2c4xez132caw2w3cpr1il98fssf.wpengine.netdna-cdn.com/wp-content/uploads/2014/08/VitalData-FullReport-20140804.pdf>. Accessed January 6, 2015.

<sup>2</sup>The Henry J. Kaiser Family Foundation. Key Facts about the Uninsured Population. <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population>. Last modified October 29, 2014. Accessed January 6, 2015.

**should include the full range of providers offering primary through quaternary care to the nation’s most vulnerable patients.**

There has been a troubling trend among insurance carriers, including those offering QHPs in the marketplaces. Their tendency is to develop narrow networks of providers that exclude essential hospitals and other providers who are trained in providing care to diverse patients. Many QHPs offered through the marketplaces currently have insufficient provider networks that cannot guarantee access to necessary services for vulnerable populations, including racial and ethnic minorities and other individuals with special health care needs. A recent study of the plans offered through the marketplaces confirmed this trend, finding that nearly half of QHPs have narrow networks, which exclude 30 percent or more of hospitals in the plan’s rating area. In the country’s largest cities this phenomenon is even more pronounced, with 60 percent of QHP networks being narrow.<sup>3</sup> To address this trend, NAIC should strengthen the network adequacy language in the model act, incorporating the following recommendations.

- a. NAIC should revise the network adequacy section to ensure the language requires issuers to include ECPs in plan networks.

**NAIC should revise the language of the network adequacy standard in section 5, subsection A, to list the types of providers that a health insurance carrier shall include in a health plan.** The revised first sentence of the paragraph would read as follows (added language in italics):

- “A health carrier providing a network plan shall maintain a network that is sufficient in numbers and types of providers, *including providers that offer access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care, public health services, mental health services, and substance abuse services,* to assure that all services to covered persons will be accessible without unreasonable delay.”

Adding this language will ensure all types of providers critical to vulnerable patients are included in networks. Furthermore, the language on mental health and substance abuse services is consistent with the federal network adequacy standard.<sup>4</sup>

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<sup>3</sup>McKinsey & Company. Hospital Networks: Updated National View on Configurations on the Exchanges. [http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29\\_0.pdf](http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf). Accessed January 6, 2015.

<sup>4</sup>45 CFR 156.230(a)(2).

NAIC should also remove language in section 5, subsection B, stating that network sufficiency “may be established by reference to any reasonable criteria used by the carrier” and instead develop a comprehensive list of criteria against which state regulators will assess all insurance carriers. The current draft language is vague, leaving open to interpretation the term “reasonable criteria,” and it gives the insurance carrier excessive discretion with which to determine network sufficiency criteria.

NAIC should include the following network sufficiency criteria in subsection B:

- the number and type of ECPs in the network, including the offering of good faith contracts to all ECP hospitals in each county in the plan’s service area
- provision of linguistically and culturally appropriate care and other services tailored to low-income and vulnerable populations
- with regard to institutional providers, the availability of trauma care, public health services, behavioral health and substance abuse services, and wraparound services critical to vulnerable patients

Including ECP requirements in the criteria will align the model act with federal regulations on QHPs, which specifically define and require the inclusion of ECPs in QHP networks.

- b. NAIC should strengthen network adequacy requirements by adding provisions that regulate the use of tiered network arrangements.

**NAIC should add a separate subsection in section 5 with language requiring carriers to follow strict requirements if they develop tiered networks.** In an effort to reduce costs in the marketplaces and other insurance markets, carriers use tiered networks in which they pay certain providers less and consumers pay more out of pocket. The QHPs place providers into different tiers with different reimbursement rates for covered services. Hospitals in preferred tiers have the lowest out-of-pocket costs for patients. Patient costs rise when they seek care in hospitals placed in less favorable tiers. Many essential hospitals have been placed in less favorable tiers because of the higher costs they incur when treating their more complex patients. They were offered a better tier only if they accepted reimbursement rates at levels far below the cost of providing care to their vulnerable patient populations. As a result, many vulnerable patients now face losing access to their established providers and their vital hospital services or paying more out of pocket, which they can rarely afford.

**To mitigate these concerns, NAIC’s model act should require special scrutiny of tiered networks to ensure access to essential providers is not**

**compromised by the use of this network structure.** This should include prohibiting carriers who offer tiered networks from arbitrarily placing ECP hospitals in the highest cost-sharing tier. Carriers should be required to ensure the same benefits are available across tiers in the QHP. These strict guidelines will protect vulnerable patients' access to affordable care offered by essential providers.

2. NAIC should require prior approval of access plans with stringent standards to ensure network adequacy.

**NAIC should revise the provisions of the model act to require insurance carriers to submit access plans to the state insurance commissioner for approval prior to offering plans through the marketplace.** The current draft of the model act has two different options that states may adopt. The first option only requires insurance carriers to file an access plan with the state insurance commissioner. The second option requires insurance carriers to file an access plan for prior approval with the state insurance commissioner. Instead of offering these two options, the model act should require carriers to submit an access plan for prior approval with the state insurance commissioner for each network the carrier is offering. Requiring access plans to be filed for prior approval with the relevant state regulatory agency will allow the agency to evaluate the network against strict network adequacy criteria before approving it.

The access plan should contain information that can be used to demonstrate whether the carrier is meeting network adequacy standards. The elements required in section 5, subsection F should be bolstered as follows:

- In addition to the groups specifically listed in subsection F of section 5, the language should include other vulnerable groups with complex medical and social needs, such as low-income individuals affected by homelessness, unemployment, or other circumstances that require special care.
- A clause should be added within subsection F requiring insurance carriers to demonstrate they have offered a contract in good faith to all willing ECP hospitals in each county in the plan's service area.
- A clause should be added requiring insurance carriers to identify whether their networks are narrow, broad, or tiered.

**NAIC should also revise the language in section 10 regarding filing requirements to require prior approval of contracts by the state insurance commissioner any time a material change is made.** Material changes should include changes to the plan that would affect covered individuals' access to services, including changes in payment rates or cost-sharing. When a carrier

submits a contract with proposed material changes, the insurance commissioner should reassess the contract to ensure it still meets the requirements of the model act.

3. NAIC should include selection criteria in the model act that prohibit carriers from discriminating against providers who treat high-risk patients.

NAIC should retain and expand on the language in the draft model act that prohibits carriers from discriminating against high-risk populations. Section 6, subsection F of the draft model act outlines requirements for carriers to follow in establishing criteria for selecting and tiering providers. The language prohibits carriers from using selection criteria that discriminate against high-risk populations by excluding providers that cater to these populations. America's Essential Hospitals supports this language as an important step in preventing carriers from excluding providers based only on the fact that they treat higher-cost patients with complex needs. However, the language should be expanded to also prevent these providers from being treated inequitably by being reimbursed at lower rates or placed in higher cost-sharing tiers. The language in section 6, subsection F, subsection 3, should be amended as followed to incorporate this change (changes in italics):

- “(3) Selection criteria shall not be established in a manner:
  - (a) That would allow a health carrier to discriminate against high-risk populations by excluding providers, *reimbursing providers at lower rates, or placing providers in less favorable tiers* because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization;
  - (b) That would exclude providers, *reimburse providers at lower rates, or place providers in less favorable tiers* because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization; or
  - (c) That fails to take into account provider performance on quality metrics and patient outcomes *that are appropriately adjusted for clinical complexity and patient sociodemographic characteristics.*”

These changes will limit carriers' ability to structure their networks in ways that exclude or discriminate against providers who treat high-risk populations. Additionally, as reflected in the above change, quality metrics including those for patient outcomes should include appropriate adjustment criteria to account for the sociodemographic characteristics of patients treated at essential hospitals.

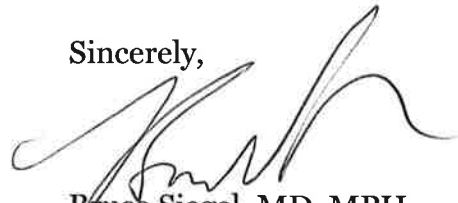
4. NAIC should amend the model act to require publicly available provider directories to display specific information that is useful to consumers.

**NAIC should require insurance carriers to file publicly accessible provider directories that contain information useful to consumers who are choosing a health plan.** The draft model act's requirement to have publicly accessible provider directories is a positive step and is in line with federal network adequacy requirements. However, provider directories should also include information about which health plan networks providers are participating in, including what consumers' expected out-of-pocket responsibility will be. Provider directories often contain inaccurate or incomplete information, so requiring carriers to follow these guidelines will be useful in helping consumers understand all of the factors involved in their insurance plan. **To allow consumers to have complete information about their plans' provider networks, NAIC should incorporate the suggested amendments when finalizing the requirement in the model act that requires carriers to publish provider directories.**

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America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Xiaoyi Huang, director of policy, at 202-585-0127.

Sincerely,



**Bruce Siegel, MD, MPH  
President and CEO**