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October 27, 2015

The Honorable Roger A. Seigny  
Commissioner  
New Hampshire Insurance Department  
21 South Fruit Street, Suite 14  
Concord, NH 03301

The Honorable Mike Kreidler  
Commissioner  
Office of the Commissioner of Insurance  
Insurance Building, Capitol Campus  
Olympia, WA 98504

## **Re: Comments on Draft NAIC Network Adequacy Model Bill**

Dear Commissioners:

We appreciate your efforts to develop model legislation to better assure our patients have access to comprehensive physician and hospital networks offered by health insurers. Patients are increasingly facing the situation where their insurers charge them exorbitant premiums and impose enormous cost-sharing responsibilities, and in return are given limited networks with little if any out of network coverage. This is of concern to our patients and our profession and must be addressed.

As set forth below, we are pleased by some of the suggested changes in this proposal to better assure comprehensive insurer networks as well as assuring more accurate listings. However, we are concerned by many other provisions which we believe do not go nearly far enough, and in some cases are far weaker than New York's law.

### **Prior approval of networks**

We are concerned that the Model Act does not specifically require regulator approval of participating physician networks before they are offered to the public. Instead, they are presented as an option for Legislatures to consider. This is not sufficient. In New York, one of the most important components of its recently enacted "surprise medical bill" law was a provision that required the Department of Financial Services to review the adequacy of the networks of all health insurance products, not just HMO products. Moreover, if a network is lacking a sufficient number specialists, the plan can be required to provide this coverage for their enrollees on an out of network basis, and patients are given new rights to take an "external appeal" to show that a particular network lacks a specialist needed by the patient.

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 belatedly discovering the challenges posed by bare minimum resources. 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. We respectfully ask that the Task Force clarify that prior approval of networks is the only appropriate option.

### **Establishment of quantitative standards**

The draft model act outlines several types of quantitative measurements that may be used to demonstrate that a health plan network is accurate, while allowing regulators to adopt specific thresholds reasonable for their state. Unfortunately, the current draft model act provides these measures as an option for states, rather than a requirement. We urge that the draft model act be modified to set forth strong quantitative standards to assure adequate networks, including time, distance and wait time standards that assure that patients do not have to, in fact, travel long distances to receive needed care, or have to wait unduly long periods of time before they can be treated by appropriately trained specialists and sub-specialists. 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.

We are pleased that the model act includes some provisions to better assure networks are truly adequate, including requiring health insurers to conduct self-audits to assure its provider lists are accurate, and requiring plans to update its public directory lists every 30 days. A recent MSSNY survey concluded that 44% of respondents reported that they were inappropriately listed on a health plan website as a participating provider in the last year. We are very concerned that health insurers are inappropriately presenting to regulators and the public that their networks are comprehensive when in fact many list non-participating providers who have dropped those products, are retired or deceased.

### **Regulation of tiered networks**

We are concerned that tiered networks, as defined under the draft Model Act, may be designed in discriminatory ways, and result in cost-shifting onto patients for covered services. For example, it is reasonably foreseeable that physicians who provide care to patients with complex health care needs will be placed in a high cost-sharing tier, so these patients may have to 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 all networks be required to meet network adequacy requirements, regardless of the cost-sharing tier.

### **Out of Network**

We have very serious concerns with the provisions of the proposal (Section 7) that would give health insurers extraordinary new powers to limit payments for out of network coverage. To begin with, we are not clear why a proposal meant to regulate health insurers is actually regulating rates of physician payment. Moreover, we agree with other organizations that have asserted that a network that does not provide sufficient access to in-network physician care at in-network hospitals should not be offered to consumers. We continue to believe that the failure of insurers to include a sufficient number of in-network physicians in their networks is the fundamental problem that leads to "surprise" billing issues, and is not adequately addressed in this proposal.

As written, we are very concerned that this provision would serve as a strong disincentive to insurers to create comprehensive networks. Insurers would have little if any need to proactively work to prevent situations where their enrollees would receive care from an out of network provider. It would seriously undermine many of the other very positive provisions in this proposal. It would give enormous new powers to health insurance companies, far different than the very carefully crafted compromise law enacted in New York State in 2014 that balanced the need for patients to avoid facing sometimes very large "surprise" medical bills with the need to assure that physicians are paid fairly for providing this needed care in often life-threatening situations. The law was implemented earlier this year and we are closely monitoring its progress. However, what is proposed by the NAIC is grossly unfair to physicians by deeming that an insurer's greatly discounted in-network payment or the woefully inadequate Medicare payment is a reasonable payment. This is substantially different than New York's law which creates a simplified independent dispute resolution process to arrive at a fee by reviewing a number of factors, including the specific expertise of the out of network physician, the

circumstances of the care being delivered, and the amount that out of network physicians in that region typically charge for a similar service. We urge the NAIC to revise this component to either delete this provision in its entirety, at least revise it so that it is substantially similar to the New York provisions.

Thank you for permitting us the opportunity to comment on this proposal.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe R. Maldonado Jr.", with a stylized flourish at the end.

**JOSEPH R. MALDONADO, Jr., MD, MSc, MBA, DipEBHC**

JRM/MMA