



Sound Policy. Quality Care.

January 10, 2015

RE: Comments by the Alliance of Specialty Medicine on the National Association of Insurance Commissioners' *Health Benefit Plan Network Access and Adequacy Model Act*

Submitted via email to: Jolie Matthews (jmatthews@naic.org)

Dear Ms. Matthews:

The Alliance of Specialty Medicine thanks you for the opportunity to provide input on the *Health Benefit Plan Network Access and Adequacy Model Act* ("the Model Act"). The Alliance is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

As specialists and subspecialists, our members are greatly affected by today's ever-narrowing networks. Access issues as a result of too-narrow networks have been well-documented in the media,¹ and we appreciate NAIC updating its Model Act to ensure that patients in managed care plans have access to the care they need. The Alliance has a few concerns related to the draft Model Act that we hope NAIC will consider as it finalizes the Model Act.

First, with regard to provider directories, **we urge NAIC to include language requiring plans to update external-facing provider directories at the same time as internal databases.**

Directory issues have been pervasive in the new exchanges: in fact, in one state, the entire provider directory was withdrawn twice due to inaccuracies.² Given that seeking care out-of-network can have serious financial implications for patients, there should be a zero-tolerance policy for outdated, inaccurate, and indecipherable directories.

Additionally, databases should distinguish between specialists and subspecialists. For example, within in-network dermatologists, a patient should be able to search for Mohs micrographic surgeons, a recognized subspecialty of dermatology. As another example, a patient using the directory should be able to differentiate between spine specialists who are orthopedic surgeons, neurosurgeons, interventional pain management physicians, or physiatrists. The National Uniform Claims Committee (NUCC) has developed alphanumeric codes that help distinguish between specialists and subspecialists, which may be useful to health plans in implementing such a requirement. These codes are routinely used by the Centers for Medicare and Medicaid Services (CMS) in the Medicare program to recognize specialty and subspecialty physicians.

In addition, a database should offer physicians the opportunity to indicate board certification, which means either (i) certification by a member board of the American Board of Medical

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American Society of Cataract & Refractive Surgery • American Society of Echocardiography • American Society of Plastic Surgeons
American Urological Association • Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons
National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions • Society for Excellence in Eyecare

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.

“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.

Second, with regard to the criteria used to assess network adequacy, we appreciate NAIC including “provider-covered person ratios by specialty” as a criterion, but **urge NAIC to include subspecialists in that ratio**. This information would be helpful during appeals processes when covered persons seek care out-of-network because a specific subspecialist is needed but unavailable in-network within a reasonable timeframe.

Third, we support the Model Act’s sixty-day notice period for no-cause terminations, but **urge NAIC to add language requiring plans to provide a clear and detailed rationale for such a decision and an opportunity for the provider to dispute the termination**. We also **urge NAIC to add language prohibiting without-cause terminations based solely on cost, without consideration of clinical quality and outcomes**.

Lastly, with respect to tiered network plans, we are concerned about tier switching in the middle of plan years. To avoid interruptions in patient care, we **urge NAIC to include language requiring insurers to implement tiering decisions prior to consumers committing for the year – and to either honor those plan design decisions or hold harmless patients from any resulting increases in cost-sharing until the next plan renewal date**.

We hope these comments are helpful to you as you finalize the Model Act and we are eager to help draft specific language to incorporate some of these suggestions, should that be helpful. Please do not hesitate to contact Judith Gorsuch (jgorsuch@hhs.com) should you require additional information.

Sincerely,

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¹ See, e.g., “Specialty Care Is A Challenge In Some ACA Plans” by Carrie Feibel, *Houston Public Media* (July 16, 2014).

² “California Health Exchange Pulls Error-Ridden Physician List – Again” by Chad Terhune, *Los Angeles Times* (Feb. 7, 2014)