Date: June 10, 2016

To: Brian Hoffmeister, JD
Director of Policy Analysis
Tennessee Department of Commerce and Insurance

From: American Society of Anesthesiologists (ASA)
American College of Radiology (ACR)
College of American Pathologists (CAP)

Re: Comments on NAIC Model Bill Section 4-6

Thank you for providing the opportunity for physician stakeholder groups to provide technical comments and requests for changes pertaining to **sections 4, 5 and 6** of the NAIC Model Bill on Network Adequacy. **Furthermore, please note that we strongly oppose the Model Act's regulation of physician out-of-network billing as prescribed under section 7 of the NAIC Model Bill on Network Adequacy. Our concerns on Section 7, as you may know, were consistently communicated by us to NAIC at the time of their consideration of this section and before their adoption of the Model Act**. We look forward to constructively engaging on these issues with the Department and the Tennessee state legislature.

The undersigned hospital based physician specialties believe that section 5 of the NAIC Network Adequacy Model Bill is insufficient in ensuring that enrollees have **reasonable access** to in-network physicians at in network facilities and hospitals. Moreover, the NAIC provided no financial protection for patients unable to access in-network physicians at in-network facilities and hospitals.

As a general statement of principle, we believe that when patients have no reasonable access to in-network physicians and are unable access such physicians at in-network facilities and hospitals, it reflects the inadequacy and failure of the health plan. Accordingly, as such, the health plan should hold the enrollee only responsible for payment based on the in-network amount that would be applicable had the service been rendered in-network (including co-payments, co-insurance and deductibles).

Any balance bill amount to the enrollee should be the financial responsibly of the **health plan** to resolve and to pay **"physicians fairly and equitably for emergency and out-of-network bills in a hospital. Any legislation that addresses the issue should assure that health plan payment for such care be based upon a number of factors, including the physicians usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician." (AMA policy) Calculation of "usual and customary" should be based upon an independent market charge database (such as Fair Health Inc.) using the 80 percentile as the standard.**

By contrast, we point out that NAIC regulators compel patients invoking the protections under Section 5 to pay balance bill amounts with no financial assumption of responsibility by the health plan to ensure that patient out-of-pocket expenses are limited.

Accordingly, the undersigned hospital-based physician specialties support the following section 5 provision of the NAIC Model Bill on Network Adequacy, **with the following changes underscored and in red font**:

Network Adequacy

A. (1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

B. The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care professional-covered person ratios;

(3) Geographic accessibility of providers;

(4) Geographic variation and population dispersion;

(5) Waiting times for an appointment with participating providers;

(6) Hours of operation;

(7) The ability of the network to meet the needs of covered persons, which may include low-income persons, children and adults with serious, chronic or complex health conditions or physical or mental disabilities or persons with limited English proficiency;

(8) Other health care service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care; and

(9) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

(10) **Whether the network includes physicians who specialize in emergency medicine, anesthesiology, pathology, radiology and hospitalists in sufficient numbers at any in-network facility or in-**

network hospital included in such plan so that patients enrolled in these plans have reasonable access to these in-network physician specialists.

C. (1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(a) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(b) The health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider as provided in Paragraph (1) when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

(b) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to Paragraph (B)(2), **or in the case of enrollee's inability to access an in-network facility or hospital based physician at an in-network facility or hospital,** as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) Pursuant to Paragraph (B) (3) The covered person may assign any balance bill expense greater than the enrollees in-network cost for such services to the health plan that will be responsible for such payments.

The process described under Paragraphs (1) and (2) shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

The undersigned hospital based physician specialties appreciate your consideration of our language, as set forth above, as we believe it properly promotes patient financial protections while holding the health plan responsible for failures in network adequacy.

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