AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

On behalf of the American Academy of Family Physicians, a medical society representing 116,900 family physicians, we appreciate the opportunity to comment on the National Association of Insurance Commissioners' draft model Network Adequacy Legislation.

Network adequacy is an important issue for our members, and we welcome this occasion to offer constructive feedback on insurance networks in order to work together with insurance commissioners and payers to ensure that our physicians are able to offer appropriate, high quality, less costly health insurance for patients.

Overall, the model legislation will place an emphasis on ensuring covered persons have access to primary care medical homes that can coordinate care, behavioral health services, and hospital-based care to meet specific needs. This emphasis aligns closely with the AAFP's policy on continuity of care as "a hallmark and primary objective of family medicine" and "[facilitating] the family physician's role as a cost-effective coordinator of the patient's health services." Strong network adequacy standards will have the ancillary effect of promoting the primary care medical home model as a way to deliver higher quality, lower costs, and a stronger patient-physician relationship. Our additional comments are organized by draft bill section in order to most effectively address areas of the legislation that would be particularly of concern for our members.

Section 2. Purpose

1. Under subsection B, the AAFP asks that NAIC consider adding "Plan must maintain up-to-date clinician listings;" this can be added as a new item, or attached to B(2) before the words "…maintain publicly available…"

Section 3. Definitions

1. We ask that NAIC consider clearly defining "material change" because the term is used throughout the model legislation and acts as the trigger for notification and filing requirements.
2. As the model legislation deals primarily with network adequacy, we suggest defining the following terms:
    a. *Broad network*
    b. *Narrow network*
    c. *Tiered network*
    d. *Ultra-narrow network*

McKinsey and Company defines these terms based on hospital participation:

a. *Broad networks have more than 70 percent of hospitals participating*
b. *Narrow networks have 31-70 percent of hospitals participating*
c. *Tiered networks put hospitals into plan-tiers with varying co-pay amounts*
d. *Ultra-narrow networks have less than 30 percent of hospitals participating*

The AAFP believes that hospital participation is a good benchmark to use; however, primary care capacity should be the focal point of network adequacy and should include the percentages of family physicians and other primary care physicians participating in networks. In addition, we ask that

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population levels be factored into the definition. For example, an area with a large population and with a large number of hospitals may not need the same percentage of participation, compared to an area with a smaller population.

3. AAFP believes that "Facility" should include outpatient and solo or group practitioner offices.

4. AAFP would also like NAIC to address "Health Care Professional" in the phrase "…licensed, accredited or certified to perform specified health services consistent with state law." We suggest inserting the phrase "their scope of practice under" between "with" and "state."

Section 5. Network Adequacy

1. Subsection A focuses network adequacy on providing services without unreasonable delay. The AAFP believes that focus on network adequacy also should include whether services can be provided to covered persons without unreasonable cost or imposing undue financial strain. In some circumstances, there may be no delay, but the cost could be high for diagnoses or treatments.

2. Subsection B enumerates various factors in determining network adequacy. Regarding the ratios for primary care physicians to covered persons and for physician to covered persons by specialty, AAFP asks that physician FTEs be accounted, because there may be physicians who are part-time or in multiple locations. In addition, non-physician providers (i.e., nurse practitioners and physician assistants) should not be counted because listing these providers because listing these providers creates the illusion that there is more access to physicians than is actually accurate, especially in states where these providers do not have independent practice authority. We ask NAIC to also consider another factor, namely hours of operation, which should be clarified to mean hours of physician availability.

3. Subsection F describes what the access plan shall describe or contain.

a. Part 1 mandates how the use of telehealth/telemedicine or other technology may be used to meet network adequacy standards—the AAFP urges that this section should clearly emphasize that health carriers should not use these distant-site consultations as a replacement for face-to-face encounters.

b. Part 4 increases transparency for network creation, specifically by directing health carriers to create their networks using consumer-friendly language in detailing the criteria used in their access plan. However, the AAFP suggests that it would be useful for physicians, regulators, and policymakers to know the specific performance, quality, and outcome methodology and metrics used in selecting or terminating physicians from networks in the access plan, regardless if it is consumer-friendly.

Section 6. Requirements for Health Carrier and Participating Providers

1. While Subsection F reinforces health carriers' use of performance, quality, and outcome methodology and metrics in selecting or terminating physicians from networks, the AAFP suggests that it also should also ensure carriers notify providers that the reason for termination was due to low metrics. This aligns with the AAFP's policy on transparency in "reporting information which can be easily verified for accuracy" on "payer's data analysis methodology and performance measures used in rating," "physician performance," and "reporting of physician health care cost and quality information." Transparency in network design will blunt the narrow network proponent's argument of lower costs because the quality and outcomes of these networks will command a greater focus.

a. In addition, for part 3(b), the AAFP suggests that it would be prudent to make comparisons within specialties and subspecialties, respectively.

2. Subsection L, part 1(a) creates a sixty-day written notice requirement to physicians for terminating without cause. CMS requires ninety days, and the AAFP believes that this model legislation should align with CMS standards.

a. In addition, the AAFP urges that changing services or providers to the detriment of covered persons should be prohibited in the middle of the contract year. The drafting note contemplates consequences for changes to policies and networks in the middle of the contract year, but those notes

are not codified in the model legislation. If there is a reduction of services or physicians to a covered person in the middle of the contract year, then it is a de facto increase in premiums or cost-sharing. The AAFP believes that patients should not be responsible for a network's inadequacy in keeping costs low by creating a narrower network mid-year. We strongly suggest that mid-year drops of physicians from networks, resulting in increased cost sharing or premiums, should be prohibited.

b. Part 1(b) creates a thirty-day written notice requirement to covered persons for terminating physicians. The AAFP suggests that the notice requirement should also be increased to ninety days. Notification should be sent to all covered persons who have seen the physicians at least once during the three years leading up to the termination date, rather than to covered persons who have been seen on a regular basis. In addition, the term "regular basis" should be defined and could exclude healthy people who see their primary care doctor yearly or every two years.

c. Parts 2 and 3 ensure continuity of care for covered persons with their initial physician, who has been terminated, for a defined period of time, depending on the medical condition. While the goal should be to avoid terminating physicians without cause, this aligns with the AAFP's policy on continuity of care for "ongoing health care management toward the goal of high quality, cost-effective medical care." These parts give covered persons a buffer to continue to receive care and treatment from their trusted physicians at a time when they would have otherwise lost their physicians through termination from a network.

3. Subsection H mentions an appeals process for providers who are terminated, but does not address the current problem with the appeals process. For most, if not all, health carriers, the appeals process is internal and the health carrier is the judge and jury and the terminated physician has little-to-no recourse to reverse a termination decision. The AAFP asks that NAIC consider removing the appeals process from within health carriers and having it arbitrated by an independent third party in this legislation. The AAFP believes that the appeals process for physicians should be fair, timely, transparent, and rarely needed. In addition, we urge NAIC to adopt an appeals process for covered persons should be codified to mirror the premise for physicians' appeals and should protect patients from delayed and fragmented care, along with high out-of-pocket cost-sharing increases or premium hikes.

Section 8. Provider Directories

1. Subsection B and C detail what information needs to be included in the online and print provider directories. While it includes listing the specialty, the AAFP urges that this section also list subspecialties. Accurate and up-to-date provider directories will have the dual-benefit for patients in finding the care they need and for providers in making referrals when further, specialized treatment is warranted. While much of the work will rest with payers to create and maintain the list, physicians and other clinicians will and should have the responsibility of making sure they inform payers as to whether they are taking new patients or have stopped doing so.

2. The drafting note mentions requiring health carriers to contact physicians in some manner, such as an automated process, when that clinician has not submitted a claim within a defined timeframe to determine whether the physician still intends to be in network. The AAFP urges that this drafting note should be moved into the draft legislative language to codify.

3. The AAFP suggests that "current" should be defined earlier in the subsection. Section 8(A)(1) says posting online a current list of physicians and other clinicians, "current" needs to be defined to mean timely updates.