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BY ELECTRONIC DELIVERY

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Executive Headquarters
National Association of Insurance Commissioners
701 Hall of the States Building
444 North Capitol Street, N.W.
Washington, DC 20001-1509

Re: Health Benefit Plan Network Access and Adequacy Model Act (Model #74)

Dear Ms. Matthews:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to submit the following comments on the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act #74 ("revised Model Act").¹ We also appreciate the opportunity to have participated as an interested stakeholder in the thoughtful discussions of the NAIC Regulatory Framework (B) Task Force's Network Adequacy Model Review (B) Subgroup as it sought to review and update the model standards for network adequacy. BIO represents more than 1,000 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO membership includes manufacturers and developers of vaccines, therapeutics, and diagnostics, and we have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help expand access to preventive, wellness, and therapeutic services for all individuals, including access to a wide range of appropriate health care professionals.

BIO is a consistent advocate that more must be done to ensure that all forms of insurance coverage provide timely, accessible and reliable access to care. For example, patients must be able to access the providers most appropriate for them, namely, those with the expertise to provide highly-specialized care if needed, those in sufficient proximity to patients, and those who can provide essential care promised by the Affordable Care Act (ACA) and other federal and state laws in a timely manner in settings where patients may already seek care. We firmly believe that standards for network adequacy must ensure meaningful coverage for all medically necessary care. This includes the benefits required by the ACA, such as preventive services—including immunizations—that virtually all plans must cover without cost sharing.

In general, we feel that the revised Model Act has made important strides toward ensuring patients have access to the most appropriate providers to obtain covered benefits. Nonetheless, we have included comments below that seek to strengthen the revised Model Act in several places to better achieve this aim.

¹ National Association of Insurance Commissioners. 2014 (November 12). *Health Benefit Plan Network Access and Adequacy Model Act*, available at: http://www.naic.org/documents/committees_b_rftf_namr_sq_exposure_draft_proposed_revisions_mcpna_model_act.pdf (hereafter "NAIC Revised Model Act").

I. BIO asks that NAIC consider reexamining whether the terms defined are necessary to the revised Model Act, accurately reflect preexisting federal requirements, and are likely to ensure patient access to the most appropriate providers for their healthcare needs.

In the revised Section 3, NAIC makes several significant changes to the definitions of several terms, chief among them, how plans subject to these requirements are identified. For example, NAIC replaces the original term “managed care plan” with any “network plan.”² BIO appreciates that the new terminology still seeks to maintain the breadth of plans to which the Model Act would apply. We believe this is important given the need to ensure similar access standards for insured patients within a given state. Additionally, NAIC adds a definition of “balance bill” in Section 3, yet BIO notes that the term is not used within the revised Model Act itself.³ This, coupled with the negative impact of balance billing practices on patient out-of-pocket costs, is cause to reexamine the need to introduce the term at all. NAIC also adds a definition of “essential community providers,” noting that the definition was added not because the term is used in the revised Model Act, but because issuers also are subject to these federal requirements that impact provider networks.⁴ BIO appreciates NAIC’s recognition of existing federal requirements for plan networks, but suggests that the revised Model Act simply provide language requiring alignment with the current federal definition and requirements, rather than a more detailed descriptive definition.

NAIC also includes a “Note to Subgroup” in this section on the addition of the term “pharmacy” to the definition of “health care provider.”⁵ BIO supports the addition of the term, but only if it specifically delineates that “‘Health care provider’ or ‘provider’ means a health care professional, a retail pharmacy, a specialty pharmacy, or a facility [underlined text represents proposed additions].” We believe that this edit would better ensure that plans include a sufficient number and breadth of retail and specialty pharmacies in-network. Specialty pharmacies, in particular, can be the exclusive suppliers of products and services on which many patients may rely, and a lack of access to these pharmacies may discourage enrollment by patients with certain healthcare needs (e.g., those in need of complex and/or chronic care). NAIC also should consider including a drafting note below this edited definition to encourage states to identify specific standards for the inclusion of specialty pharmacies in-network. In particular, BIO notes that including more than one specialty pharmacy in-network is beneficial since not all specialty pharmacies have experience dealing with certain, highly complex diseases nor do they necessarily carry a sufficiently broad range of products. In amending this section, NAIC should focus on how to best ensure that patients have access to a knowledgeable pharmacy and the most appropriate products for them.

II. BIO supports NAIC’s clarification that the utility of accreditation is as a supplement, not substitute, to state regulatory authority regarding compliance with network adequacy standards.

In Section 4, NAIC revises the drafting note that clarifies its intent around the inclusion of the applicability and scope requirements. BIO strongly concurs with the additional text in the drafting note stating that “accreditation should not be used as a substitute for state regulatory oversight nor should accreditation be considered a delegation of state regulatory authority in determining network adequacy. States should consider accreditation as an

² NAIC Revised Model Act at p. 4.

³ *Id.* at p.2.

⁴ *Id.* at p.3.

⁵ *Id.* at p. 3.

additional regulatory tool in determining compliance with the standards required under this Act.”⁶ This is an important point that is critical to ensure accountability at the state level for the sufficiency of plans’ networks. Nonetheless, we agree that accreditation, if it meets standards “that, at a minimum, are substantially similar to or exceed the standards required under this Act,”⁷ can be an important regulatory tool for the state.

III. BIO urges NAIC to continue to strengthen the network adequacy requirements in Section 5 of the revised Model Act to better meet the goal of ensuring patient access to the most appropriate providers for all their healthcare needs.

A. BIO urges NAIC to further strengthen patient protections with regard to tiered networks by specifying that network adequacy standards included in the revised Model Act apply to each network tier.

In revised Section 5, NAIC includes a drafting note describing how network adequacy may be impacted by tiered networks. This section was added after deliberations within the Subgroup on the importance of addressing this issue with the revised Model Act. BIO agrees with the inclusion of a drafting note on the subject of tiered networks, and asks NAIC to include this text in the final Model Act.⁸ Identifying tiered networks, due to their complexity and the potential for variation between networks, is important as states consider putting into place mechanisms to review marketing and promotional activities around plans utilizing tiered networks. Specifically, states must ensure the information available to patients is clear and accurately reflects the services a patient will be able to access. However, BIO is concerned that the revised Model Act does not specify access-to-care standards that tiered networks must meet, a concern discussed in more detail in response to changes in Section 6 of the revised Model Act (see below).

B. BIO urges NAIC to finalize the patient protections included in the revised Model Act for patients who need to seek care from out-of-network providers.

BIO applauds NAIC for including a specific subsection in the revised Model Act that identifies the need for plans to have in place a specific process for a covered patient to request access to services provided by an out-of-network provider.⁹ We also support, and urge NAIC to finalize, the criteria the revised Model Act establishes for these out-of-network exceptions, namely that they are appropriate in instances where the health carrier: “does not have a network provider of the required specialty with the professional training and expertise to treat a patient; or cannot provide reasonable access to a network provider with the professional training and expertise [necessary]...without unreasonable delay.”¹⁰ We believe this comprehensive definition is crucial to ensure covered patients are able to ask for and receive access to covered benefits in instances where an in-network provider is not available (e.g., does not have the requisite experience or training to appropriately diagnose and treat a patient in a timely manner). This is especially important for patients with rare diseases, for whom there may be only a few specialists in the country capable of offering appropriate care. We also strongly support, and urge NAIC to finalize, the language in the revised Model Act that requires a health carrier to treat services obtained from a non-network provider “as

⁶ Id. at p. 4.

⁷ Id. at p. 4.

⁸ Id. at p.5

⁹ Id. at p.6.

¹⁰ Id. at p.6.

if the services were provided by a network provider.”¹¹ This provision is also crucial to ensuring that insured patients who need to obtain care or other services from a non-network provider are not subject to higher cost-sharing requirements than if the provider were included in the network, and that costs expended on covered services count toward the patient’s annual out-of-pocket maximum limit. Cost-sharing has an inversely proportional relationship to adherence to care¹² and patients’ willingness/ability to seek appropriate care, thus higher cost sharing for out-of-network provider services can have a negative impact on patients’ short- and longer-term health outcomes.

- C. BIO urges NAIC to require states to have mechanisms in place to prevent plans that do not meet the revised Model Act’s network standards from reaching the marketplace.

BIO understands NAIC’s intent behind including two options in the revised Model Act for the required Access Plan, namely to provide flexibility for states with limited resources (i.e., some states do not have the resources to be able to proactively review and approve the access plan of each network plan operating in the state).¹³ However, we remain concerned that without a mechanism to identify plans that do not meet the requirements and standards of the revised Model Act, plans with discriminatory benefit designs may reach the marketplace. Thus, we reiterate our earlier recommendation to NAIC that the revised Model Act require that every state have a mechanism in place to focus limited resources on rigorous reviews of potentially noncompliant plans (e.g., as reported by stakeholders through a designated mechanism) or perform selective reviews of plans that cover the hardest-to-serve patient populations. At the very least, we ask that NAIC include this suggestion in the second Drafting Note on page 7 of the revised Model Act following the text on “Option 2” for states to consider individually.

- D. BIO urges NAIC to finalize the proposed requirements should a plan make material changes to its provider network once submitted to the state, and asks that NAIC consider establishing a single definition of material change to encourage a single standard across all markets.

BIO supports and urges NAIC to finalize the added language in subsection 3 on page 8 of the revised Model Act that requires plans to “notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs... [and include] a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an updated an [*sic*] existing access plan.”¹⁴ The Drafting Note below this additional language should cross-reference the discussion of defining “material change” on page 16 of the revised Model Act, Section 10. Additionally, BIO asks that NAIC include in the Drafting Note a request that states consider implementing a definition for “material change” such that all non-nominal changes to “coinsurance, [or] copayments or deductibles”¹⁵ be considered material changes subject to the Act’s provisions unless a plan submits, and the commissioner approves, a justification to the contrary. This provision is important because even a small increase in

¹¹ Id. at p.6.

¹² For example, see Eaddy, M. T., C. L. Cook, K. O’Day, S. P. Burch, and C. R. Cantrell. 2012. How patient cost-sharing trends affect adherence and outcomes: a literature review. *Pharmacy & Therapeutics* 37(1):45-55.

¹³ NAIC Revised Model Act at p.7.

¹⁴ Id. at p.8.

¹⁵ Id. at p.16.

patient cost-sharing can impact adherence to therapeutic regimens, and in turn, health outcomes and overall healthcare system costs.¹⁶

- E. BIO encourage NAIC to reconsider the role of telemedicine and telehealth services such that they do not replace in-person services to the extent in-person services are available and appropriate for patients.

BIO appreciates the clarification provided in the revised Model Act to the list of required issues an access plan must address, including: what telemedicine or telehealth services are included in the network; the requirement to make publicly available, in consumer-friendly language the criteria a plan uses to build its provider network; and, each plan's process for updating its provider directories.¹⁷ However, BIO reiterates our concerns around the ability of telemedicine or telehealth services to replace services available from in-network providers. BIO realizes the burgeoning potential of these services and agrees that the availability of these services should be considered in the review of a plan's network for purposes of determining adequacy. Yet, we caution NAIC that, in some cases, allowing telemedicine or telehealth services to provide an alternative to in-person care may create delays or other barriers to accessing care. Also, it is paramount to the success of telehealth services that such providers are able to deliver the same breadth of diagnostic and treatment services as in-person providers. Thus, to balance the utility of leveraging these services with the need to contextualize their potential limitations, BIO urges NAIC to consider identifying the appropriate use of telemedicine and telehealth services to *supplement*, rather than replace, in-person care.

- F. BIO urges NAIC to require plans to include complementary immunization providers in plan networks.

BIO reiterates our request that NAIC consider adding language to the Model Act requiring managed care plans to include all types of complementary immunizers in their provider networks as a means to ensure broad access to this critical preventive service. One of the most important provisions of the ACA was the establishment of the "immunization coverage standard," which requires plans to cover immunizations recommended by the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) without cost-sharing when administered by an in-network provider. Ensuring that health plans include immunization providers in their networks has been identified as a critical issue by a diverse group of stakeholders who have worked together through the National Adult and Influenza Immunization Summit (NAIIS) to advance the goals of expanding access to immunizations for the entire population and achieving the *Healthy People 2020* goals for immunization.¹⁸

Immunization services have a unique set of providers. In addition to traditional immunizers, such as pediatricians and other primary care providers, complementary immunizers—pharmacists, public health department clinicians, school-based clinicians, and other community providers operating within their state scope of practice laws—provide many vaccines. As referenced in Section 5.A. of the Model Act, services should be accessible

¹⁶ For example, see Eaddy, M. T., C. L. Cook, K. O'Day, S. P. Burch, and C. R. Cantrell. 2012. How patient cost-sharing trends affect adherence and outcomes: a literature review. *Pharmacy & Therapeutics* 37(1):45-55.

¹⁷ NAIC Revised Model Act at p.8.

¹⁸ NAIIS is a public-private partnership comprised of more than 140 organizational stakeholders, including vaccine manufacturers, professional medical societies, public health organizations, federal agencies, pharmacists, health insurers, and hospitals, among others. NAIIS has identified the issue of network adequacy for immunization providers as critical to vaccine access.

without unreasonable delay, and criteria to measure network sufficiency may include geographic accessibility, waiting times for appointments, and hours of operation. Complementary immunizers are able to meet these criteria.

Complementary immunizers are particularly important for the hard-to-reach adolescent and adult populations. Indeed, adults have demonstrated a preference to be vaccinated outside of their medical home, where and when it is convenient for them, and the system has evolved to support that access. For instance, more than 230,000 pharmacists have been trained to administer vaccines in the United States,¹⁹ and nearly all Americans (94 percent) live within five miles of a community pharmacy.²⁰ During the 2011-2012 influenza season, nearly 20 percent of adult influenza vaccines were administered in retail pharmacies.²¹ All 50 states allow pharmacists to administer pneumococcal and zoster vaccines, and many adults seek these vaccines in the pharmacy setting.²²

Complementary immunizers also serve low-income, medically underserved populations, mitigating the barriers these vulnerable patients have long faced with respect to access to care. For instance, community pharmacies provide patient access to important immunizations against vaccine-preventable diseases, including for individuals residing in medically underserved areas (MUAs). One nationwide community pharmacy corporation, Walgreens, indicated that over one-third of their influenza vaccines administered last year were in pharmacies located in MUAs; in states with the largest MUAs, they provided up to 77.1 percent of their influenza vaccines in these areas. Moreover, of all influenza vaccinations Walgreens delivered last season, 31 percent were during off-peak times (59 percent on weekends and 31 percent in the evenings), and approximately 31 percent of patients during off-peak times were age 65 or older, and 36 percent had underlying medical conditions. Notably, efforts to provide immunizations other than influenza were complicated by lack of insurance coverage or recognition of community pharmacies as in-network providers.

Many public health stakeholders have supported efforts underway at the CDC to include additional complementary immunization sites, such as public health and school-based clinics, in provider networks. The most significant such CDC initiative, known as the "Third Party Billing Project," works with state health departments, public health clinics, and health insurers to include public health clinics in provider networks.²³ Thirty-five states and large cities are currently planning or implementing the Billing Project, which will allow them to bill insurers for immunization services provided to insured persons of all ages. Data from the Billing Project underscore the sheer volume of immunizations furnished by these complementary immunizers: in 2010, local health units billed private insurance for \$1,964,267 in immunization-related costs in North Dakota alone.²⁴ Other states such as

¹⁹ Rothholz M. Opportunities for Collaboration to Advance Progress towards "The Immunization Neighborhood:" Recognition and Compensation of Pharmacists. Presentation. American Pharmacists Association. August 30, 2012.

²⁰ NCPDP Pharmacy File, ArcGIS Census Tract File, National Association of Chain Drug Stores Economics Department.

²¹ CDC, March Flu Vaccination Coverage United States, 2011-12 Influenza Season (March 2012), available at: <http://www.cdc.gov/flu/pdf/fluview/national-flu-survey-mar2012.pdf>.

²² See American Pharmacists Association, Pharmacist Authority to Immunize, available at: <http://www.pharmacist.com/sites/default/files/PharmacistIZAuthority.pdf>.

²³ CDC, Billing Project Success Stories, <http://www.cdc.gov/vaccines/programs/billables-project/success-stories.html> (last accessed Feb. 6, 2014).

²⁴ Sander M. Lessons Learned: Billing Insurance at Local Health Units in North Dakota (PowerPoint). March 30, 2011. North Dakota Department of Health. Available at: <https://cdc.confex.com/cdc/nic2011/webprogram/Paper25418.html>.

Arizona, California, Arkansas, Georgia, and Montana experienced success with the Billing Project.²⁵

In spite of these efforts, when a health insurance plan does not include complementary immunization sites in its provider network, the ACA's intent of expanding access to immunizations is compromised. For instance, a plan enrollee who seeks to be immunized at a public health clinic or pharmacy that has been excluded from a plan's provider network would be denied first dollar coverage (or coverage at all) for that service. In turn, the patient may decide not to receive the vaccine due to cost and an immunization opportunity would be lost. Alternatively, a more affluent patient could elect to pay the bill, but none of these costs would count toward the patient's deductible, and the patient would understandably be upset and confused as to why he/she did not receive the benefits he/she was promised.²⁶

In our experience, complementary immunizers are currently being excluded from provider networks across the country. For instance, school-based clinics in Carson City, Nevada have been excluded from the network of a major health insurer. Similarly, two insurers will not contract with the School-Located Vaccine Clinic program operated by the health department in Pomperaug, Connecticut. And the Los Angeles Unified School District cannot bill insurers due to the perception that a vaccine given in a school will interfere with the medical home.

As acknowledged by the National Vaccine Advisory Committee (NVAC) in the updated Standards for Adult Immunization Practice, "there is an increased recognition of community vaccinators and pharmacists as integral to achieving higher adult vaccination rates."²⁷ BIO urges NAIC to consider requiring managed care plans to include all types of complementary immunizers in their provider networks, as expanded access to immunization services will improve vaccination rates and thereby reduce morbidity, mortality, and overall medical care costs for enrollees.

G. BIO asks NAIC to consider encouraging states to identify specific provider groups on a "list for additional scrutiny" when assessing whether plans meet provider network adequacy standards.

BIO urges NAIC to consider including a drafting note in the final Model Act that encourages each state to consider establishing a list of providers for additional scrutiny as the state reviews plans' provider networks for compliance with relevant requirements. The purpose of this list would be to help ensure that the sickest, most vulnerable patients—including those in need of complex and chronic care—are able to access providers with the requisite training and expertise in a timely manner. NAIC should note that, at a minimum, each state's list should include: dermatologists, gastroenterologist, hematologists, neurologists, oncologists, ophthalmologists, pathologists, pulmonologists, and rheumatologists. Standards for assessing whether each plan has included a sufficient number of each of these types of providers could be developed by states through regulations. NAIC also should consider the potential to identify provider subspecialties for inclusion on these lists for additional scrutiny. For example, while we believe that plans' inclusion of oncologists should be

²⁵ Kilgus D. Billing Program Final Plans. February 2012. CDC. Available at: <http://www.cdc.gov/vaccines/programs/billables-project/downloads/billing-final-plans-from-stkhldr-mtg-slides.pdf>.

²⁶ Andrews M. Consumers Expecting Free "Preventive Care" Sometimes Surprised by Charges (Jan. 21, 2014), available at: <http://www.kaiserhealthnews.org/Stories/2014/January/21/Michelle-Andrews-Consumers-Expecting-Free-Preventive-Care.aspx>.

²⁷ National Vaccine Advisory Committee. Standards for Adult Immunization Practice. Available at: http://www.hhs.gov/nvpo/nvac/meetings/pastmeetings/2013/adult_immunization_update-sept2013.pdf.

specifically assessed—given the importance of timely and convenient access to this type of specialist for those with cancer—not all cancers are the same, and access to subspecialists, where they are available in a given geographic area, can be crucial to ensuring patients obtain expert and individualized care. Thus, in the example list included in the drafting note, we ask NAIC to consider including the subspecialties of the five most prevalent cancers by incidence—breast, prostate, lung, colorectal, and melanoma. Finally, we ask that NAIC recommend that states include rare disease specialties in their list for additional scrutiny to ensure this vulnerable patient population is able to access providers with the requisite expertise to diagnose and treat these conditions.

IV. BIO supports many of the changes included in the requirements for participating health carriers and participating providers, but urges NAIC to make additional changes to the revised Model Act to further strengthen valuable patient protections.

A. BIO urges NAIC to finalize Section 6(F) with the level of detail included in the revised Model Act, but to specifically include requirements around network adequacy standards for tiered networks.

BIO appreciates the reformatted subsection F of Section 6, detailing requirements for the selection criteria a plan uses to establish provider networks, as it better elucidates the requirements in place.²⁸ BIO asks that NAIC consider including language in this section, perhaps in the form of a Drafting Note, that references the existing federal nondiscrimination requirements both for the inclusion of providers within plan networks²⁹ and in terms of benefit design.³⁰ As states implement the Model Act, compliance with these requirements should be considered as well.

Additionally, BIO is concerned that the inclusion of the reference to tiering in section F(1) is not accompanied by standards for patient access to covered services and implications for patient cost sharing within these types of networks. BIO asks that NAIC specify that all network adequacy standards included in the revised Model Act and required by federal regulations should be met by each tier in a tiered-network model. Additionally, information on tiered networks should be required to be made public in a format that is easily intelligible and clearly identifies the differences between tiers (see comments in response to Section 5 of the revised Model Act, above, for a more detailed discussion on this point). Moreover, the drafting note should clarify—or NAIC could do so in the relevant provisions of the final Model Act itself—that processes for requesting and receiving exceptions for access to out-of-network providers should be applicable across network tiers. If an appropriate provider is not available in the lowest tier (in terms of patient cost sharing), enrollees should be able to receive care from appropriate providers in higher network tiers at the same cost sharing as the lowest tier. Finally, the Model Act should include a provision (perhaps in the section on criteria used to select network providers) that prohibits the placement of a provider on a higher network tier simply because of the provider's identified specialty (e.g., all oncologists should not be relegated to a high network tier on the basis of their specialty alone).

²⁸ NAIC Revised Model Act at p. 10.

²⁹ 42 U.S.C. § 300gg-5(a).

³⁰ 42 U.S.C. § 300gg-4(a).

- B. BIO supports the recognition that quality of care is an important aspect of the criteria used to select providers for in-network inclusion, but urges NAIC to ensure that quality benchmarks accurately reflect the standard of care.

BIO supports the inclusion of a new selection criterion in the revised Model Act in Section 6(F)(3), namely that provider networks shall not be established in a manner “that fails to take into account provider performance on quality metrics and patient outcomes.”³¹ This requirement is aligned with the goal of the revised Model Act to ensure insured patients are able to access high-quality care in a timely manner. However, we urge NAIC to include a Drafting Note that any metrics of quality-of-care and patient outcomes against which provider performance is judged must:

- Be specific to the type of care provided;
- Meaningfully evaluate whether a given patient is receiving the most appropriate course of treatment; and
- Be endorsed by the National Quality Forum (NQF) or another consensus-based organization that uses similarly sophisticated processes for developing and endorsing measures.

This requirement is important since quality-of-care and patient outcomes measures are crucial in their role as a bulwark against the perverse incentives that can be brought about by a solitary focus on cost-containment (i.e., under-utilization of appropriate and medically necessary care).

- C. BIO urges NAIC to finalize the additional patient protections included in the revised Model Act with regard to provider contract terminations.

BIO supports the new requirement in the revised Model Act that, when a provider’s contract is terminated without cause, the “affected covered persons with acute or chronic medical conditions in active treatment [be allowed] to continue such treatment until it is completed or for up to ninety (90) days.”³² This patient protection is important to ensure patients undergoing care do not experience interruptions in that care that can negatively impact their short- or longer-term health outcomes. In fact, BIO urges NAIC to further strengthen this important protection by: extending it to patients with chronic conditions that are being managed, and thus do not necessarily fit the definition of active treatment; and, to allow patients to continue to receive covered services from such a provider, as if the provider were still in-network, through the end of the plan year, rather than just for the subsequent ninety days. This extension would encompass all out-of-pocket-cost requirements, such that patients would not incur higher costs than if the provider had remained in-network, and all out-of-pocket costs would continue to count toward the patient’s annual out-of-pocket maximum. Strengthening this provision in these ways would ensure continuity of care for these enrollees; disruptions in access to a provider who has been assisting a patient to manage a chronic condition could have a negative impact on patient adherence to treatment regimens and health outcomes, which NAIC is trying to avoid by including this provision in the first place. Additionally, these patients often consider provider networks when choosing a health insurance plan, so extending this requirement through the end of the benefit year would ensure enrollees are able to continue to access the network they anticipated when enrolling in a particular plan at the beginning of the year.

³¹ NAIC Revised Model Act at p. 10.

³² *Id.* at p. 11.

V. BIO urges NAIC to finalize the disclosure and notice requirements included in the revised Model Act.

In the revised Model Act, NAIC added two specific disclosure and notice requirements to better ensure that patients understand when they may receive non-emergency services from an out-of-network provider, even if the facility where the care is provided is in-network. Notifying patients of such a situation is important given the, often substantial, differences in cost-sharing for patients between covered services when rendered by in-network versus out-of-network providers.³³ BIO strongly supports the addition of this section in the revised Model Act and urges NAIC to finalize it. These requirements represent key protections that provide patients with the best information available as they make decisions about where to receive non-emergency services.

VI. BIO supports the level of detail included in the revised Model Act around requirements for information included in provider directories and urges NAIC to finalize these requirements.

In Section 8 of the revised Model Act, NAIC makes significant progress in identifying the specific pieces of information necessary to ensure that provider directories are useful to patients before and after they enroll in a health insurance plan.³⁴ Arming individuals with more information, and information that is updated in a timely manner, is a critical aspect of ensuring they are able to make well-informed decisions about the health insurance plan and/or healthcare provider that is most appropriate for their medical needs. Thus, BIO strongly supports the increased specificity in the revised Model Act of requirements for network plans' provider directories, and we urge NAIC to finalize this section in full.

VII. Conclusion

BIO applauds the NAIC for its efforts on this important issue, and appreciates the opportunity to comment on the revised Model Act. We believe this will not only help fulfill the ACA's promise of broad access to the most appropriate preventive and therapeutic care for individuals, but will have important health outcomes and public health benefits as the result of such access. If you have any questions or require any further information, please do not hesitate to contact us. Thank you for your attention to this important matter.

Sincerely,

/s/

Laurel L. Todd
Managing Director
Reimbursement and Health Policy

³³ Id. at p. 13.

³⁴ Id. at p. 13.