AMERICAN COLLEGE of NURSE-MIDWIVES
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Jolie H. Matthews
Senior Health and Policy Counsel
National Association of Insurance Commissioners
444 North Capitol Street NW
Suite 700
Washington, DC 20001
Letter via email to: jmatthews@naic.org

RE: Revisions to NAIC Managed Care Network Adequacy Model Act

Dear Ms. Matthews:

On behalf of the American College of Nurse-Midwives (ACNM) I am pleased to submit these comments on potential revisions to the National Association of Insurance Commissioner's (NAIC) Managed Care Network Adequacy Model Act. We are appreciative of the NAIC's effort to maintain an open process in this effort and look forward to the final result. We hope our comments prove useful to the NAIC as it works through its process.

ACNM is the national professional association representing Certified Nurse-Midwives (CNMs) and Certified Midwives (CMs). CNMs/CMs obtain a master's degree, complete graduate studies in midwifery and are certified by the American Midwifery Certification Board. They specialize in fostering and supporting the occurrence of normal physiologic birth. In addition to maternity care, CNMs/CMs provide a wide range of primary and well woman services throughout the lifecycle, including contraceptive care.

CNMs/CMs are licensed in all 50 states and the District of Columbia and collectively serve hundreds of thousands of women every year. Nearly 95% of births attended by CNMs/CMs occur in a hospital setting. They also attend a small number of births occurring in birth centers and private residences. Nationwide, CNMs/CMs attend 8% of all births and nearly 12% of vaginal births. In several states, CNMs/CMs attend between 15-27% of all births. They are significant providers of maternal and newborn care, a required benefit category under the essential health benefits requirements.

COMMENTS

ACNM believes the NAIC should revise the language of Section 6.F.(3) of the existing Model Act, which currently states:

> The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of

> providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

ACNM has two specific concerns with this language. First, this language clearly allows plans to refuse to contract with entire types of providers. A provision of the Public Health Services Act, Section 2706(a), added by the Affordable Care Act (ACA), does not allow this practice to take place. Section 2706(a) reads:

> A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

With regard to Section 2706(a), the Senate Appropriations Committee has written that "The goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State." The Committee goes on to say that Section 2706(a) was specifically intended to prohibit insurers from acting in a way that would "exclude from participation whole categories of providers operating under a State license or certification."[1] In other words, if a plan covers a certain benefit and there are practitioners within the plan's service area who, under applicable state law and regulation, are legally permitted to render that service, the plan may not refuse to contract with all practitioners who are so licensed. To do so is to run afoul of the anti-discrimination provisions of the statute. The NAIC should therefore ensure that its revisions to the Model Act incorporate the requirements of Section 2706(a).

ACNM's second concern arises from information we have obtained through a survey of health plans offering coverage through the health insurance marketplaces.[2] Because publicly available information does not clearly explain if CNMs/CMs are included in plans' networks, nor the extent to which their services are covered by these plans, we reached out to insurers offering coverage through the health insurance marketplaces to make inquiry. We were able to survey 85 plans, which resulted in the following key findings:

- Twenty percent of plans do not contract with CNMs to include them in their provider networks, even though CNMs are licensed to practice in all 50 states and the District of Columbia.

[1] Senate Report 113-071, available at: http://thomas.loc.gov/cgi-bin/cpquery/?&sid=cp1132kIPg&r_n=sr071.113&dbname=cp113&&sel=TOC_415278&

[2] The full report on ACNM's survey is available at: http://www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000004394/EnsuringAccesstoHighValueProviders.pdf

- Seventeen percent of plans do not cover primary care services offered by CNMs, even though ACNM standards defining the scope of practice for these providers, often incorporated by reference by state law, include primary care services.
- Fourteen percent of plans indicated they impose restrictions on CNM practice that conflict with their scope of practice under state laws and regulations.
- Twenty-four percent of plans will not cover CNM professional services provided in a birth center and 56% will not reimburse CNMs for home birth services.
- Fifty percent of plans do not pay CNMs the same amount paid to a physician when they perform and bill for the same service.
- Ten percent of plans that contract with CNMs do not list them in their provider directories, making them invisible to potential and current enrollees. Forty percent of plans listing CNMs in their provider directories list them under the obstetrician-gynecologist category, which may make it difficult for women searching for "midwives" to find them.
- Forty-seven percent of plans do not contract with birth centers to cover facility costs associated with births in that setting, despite studies showing very good outcomes and low costs associated with these facilities.
- Among those contracting with birth centers, 18% do not make a payment to the birth center for their services that is distinct from the payment made to the professionals working therein.
- Eight percent of plans contracting with birth centers indicated they did not list them in their provider directory.

Given the significant body of research demonstrating that CNMs/CMs render high quality, low cost care, these data clearly indicate that many plans are missing a significant business opportunity.

From a regulatory standpoint, however, these data also show a clear pattern of discriminatory behavior by insurers toward CNMs/CMs. It is a very serious issue that a major provider of required maternity and newborn care is being systematically and categorically excluded from full participation in plan networks purely on the basis of the type of license they hold. The NAIC should revise its Model Act to ensure that such discrimination cannot take place.

Clearly plans face very different circumstances across the country with regard to the availability of providers and the Model Act must be drafted in such a way as to accommodate those differences. However, if the NAIC were to let the existing language of Section 6.F.(3) remain unrevised, in addition to answering how that outdated language can possibly square with the newer requirements of Section 2706(a) of the PHSA, the NAIC would also have to explain what, if any limits there would be to a plan's ability to refuse to contract with entire categories of providers.

While the existing Model Act specifies that insurers must maintain a network that is "sufficient in numbers and types of providers to assure that all services to covered persons will be accessible

without unreasonable delay," the Model Act provides only general guidance around how to determine sufficiency, leaving that primarily up to the carrier. The Model Act does not specify numbers and types of providers that must be included in a plan's network, nor does it even point to an existing external standard. If the Model Act does not do this, the question must be raised about exactly how narrow the networks can become? For the sake of argument, imagine a situation where a plan asserts that it need only contract with general surgeons and no other surgical specialist. Would the NAIC be comfortable with that interpretation of its Model Act? If not, then where is that line drawn? In a time when plans are turning to increasingly narrow networks it is incumbent upon the NAIC to point to an external standard, one not selected or determined by the carriers.

The Congress has seen fit to provide just such a standard in the form of Section 2706(a). In accordance with that statutory provision, ACNM strongly encourages the NAIC to revise its Model Act to require that when plans cover a given benefit, the plan must contract with a sufficient number of each type of provider licensed to render that benefit to ensure its availability to the plan's beneficiary population. The only exception to this would be situations in which those providers are not present within the plan's service area or a reasonable distance therefrom.

CONCLUSION

We thank you for the opportunity to comment on this important project. Should you have any questions regarding our comments, please reach out to me directly.

Sincerely,

/JSB/

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