

Date: 5/11/16

Market Conduct Examination Standards (D) Working Group  
Conference Call  
May 4, 2016

The Market Conduct Examination Standards (D) Working Group of the Market Regulation and Consumer Affairs (D) Committee met via conference call May 4, 2016. The following Working Group members participated: Bruce R. Ramage, Chair, John Paul Sabby, Martin Swanson and Cindy Williamson (NE); Jim Mealer, Vice Chair (MO); Damion Hughes (CO); Kurt Swan (CT); Debra Peirce (GA); Doug Ommen (IA); Russ Hamblen (KY); Richard Bradley (MA); Sherri Mortensen-Brown (MN); Bill George (NC); Edwin Pugsley (NH); Cliff Day (NJ); Jeremy Gladstone and Peggy Willard-Ross (NV); Sharon Ma and Robert McLaughlin (NY); Angela Dingus and Jana Jarrett (OH); Brian Gabbert and Shelly Ondiak (OK); Constance Arnold (PA); Julie Fairbanks (VA); Christina Rouleau (VT); Jeannette Plitt (WA); Diane Dambach, Susan Ezalarab, MaryKay Rodriguez, John Kitslaar, Cari Lee, Jo LeDuc and Julie Walsh (WI); and Mark Hooker (WV).

1. Reviewed and Discussed Draft Health Reform Market Conduct Examination Standards – Network Adequacy, April 26 Draft for Inclusion in the *Market Regulation Handbook*

Director Ramage said that the draft new examination standards distributed for Working Group discussion were based upon the content of the recently updated NAIC model, the *Health Benefit Plan Network Access and Adequacy Act* (#74). Model #74, which was formerly known as the Network Adequacy Model Act, was adopted by the NAIC Executive (EX) Committee and Plenary at the 2015 Fall National Meeting. Mary Nugent (Center for Consumer Information and Insurance Oversight—CCIIO) had submitted comments prior to the call, which, due to time constraints, were unable to be distributed prior to the call. NAIC staff read the comments to the call participants. The CCIIO comments were in regard to whether the draft network adequacy standards would meet the network adequacy requirements outlined in pages 23-27 in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued Feb. 29, 2016, by the CCIIO. Additionally, the CCIIO asked whether states will use the draft network adequacy examination standards or develop standards of their own that are as stringent as or more stringent than the federal network adequacy standards. Director Ramage read the NAIC staff's response to the CCIIO comments, which was as follows:

Most states use the *Market Regulation Handbook* standards and related materials as a baseline for their reviews. Adjustments, where deemed appropriate by each state, are made to reference state-specific statutes or regulations. We assume that a state which has been deemed as one that assumes all of the consumer protection requirements of the Affordable Care Act (ACA), would also adjust the standards to incorporate CCIIO rules. For the most part, *Market Regulation Handbook* standards are based on NAIC models. For ACA-related standards, we attempt to also reference finalized ACA regulations.

The CCIIO comments, the NAIC's response and the CCIIO's subsequent response to the NAIC, as well as an excerpt of pages 23-27 from the CCIIO 2017 Letter to Issuers in the Federally-facilitated Marketplaces, will be posted to the Working Group Web page and distributed to the Working Group, interested regulators and interested parties.

Director Ramage said that there are two balance billing-related exam standards within the exposure draft; balance billing relates to both ACA and non-ACA. The Working Group decided that instead of reviewing the balance billing exam standards twice—as new text in the non-ACA chapter, Conducting the Health Examination, of the *Market Regulation Handbook*, and in the current exposure draft, to be incorporated into the ACA chapter, Conducting the Health Reform-Related Examination of the *Market Regulation Handbook*—the exam standards will be reviewed once, and upon adoption by the Executive (EX) Committee and Plenary, will be incorporated into both the ACA-related chapter of the *Market Regulation Handbook* and the non-ACA-related chapter of the *Market Regulation Handbook*.

Director Ramage said that any suggested language changes received by the comments due date of May 27, 2016, will be incorporated into the draft standards for review at the next Working Group call.

2. Adopted the Report of the Standardized Data Request (D) Subgroup

Mr. Hamblen said the Standardized Data Request (D) Subgroup met via conference call April 13 and March 16 in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance, including, but not limited to, annual and quarterly statement blanks and instructions, the *Accounting Practices and Procedures Manual* and similar materials) of the NAIC Policy Statement on Open Meetings.

Mr. Hamblen said that during the calls, the Subgroup worked on suggested updates to the advertising section and the complaint section of the Producer, Commission and Complaint standardized data request. Mr. Hamblen said that the Subgroup plans to next meet in May.

Mr. Hamblen made a motion, seconded by Mr. McLaughlin, to adopt the report of the Subgroup (Attachment 1). The motion passed unanimously.

### 3. Discussed 2016 Working Group Tasks

Director Rame said the Working Group will resume work on the health reform-related nondiscrimination draft exam standards (Section 1557) once final guidance has been issued by the U.S. Department of Health and Human Services (HHS), which is scheduled to occur this summer. Director Rame said that with the adoption in 2015 of the *Cybersecurity Bill of Rights*, and the recent cybersecurity-related adopted revisions to the *Financial Condition Examiners Handbook*, addressing cybersecurity issues in the *Market Regulation Handbook* is an issue the Working Group should begin focusing on this year. Director Rame said the Working Group will also be developing a new chapter for inclusion in the *Market Regulation Handbook* that will provide guidance for state insurance regulators regarding closing continuum actions. Director Rame said that a new Working Group, the Title Affiliated Business Process Review (C) Working Group, was formed under the Title Insurance (C) Task Force at the Spring National Meeting for the purpose of updating the title chapter of the *Market Regulation Handbook*. Director Rame said that Working Group will provide a final proposal to this Working Group regarding recommended updates to the title chapter.

Director Rame said the next Working Group call is scheduled to occur in June, and NAIC staff will provide advance email notice.

Having no further business, the Market Conduct Examination Standards (D) Working Group adjourned.

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**PROVISION TITLE:** Network Adequacy Standards

**CITATION:** PHSA §2702 (c) & §156.230

**EFFECTIVE DATE:** Plan years and, in the individual market, policy years beginning on or after Jan. 1, 2014

**PROVISION:** The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering health insurance coverage in the individual or group markets in a state must meet minimum criteria for adequacy of provider networks delivering covered services to covered persons.

**BACKGROUND:** Regulations and associated FAQs, issued by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) set forth minimum criteria for network adequacy that health carriers' network plans must meet in order to be certified as Qualified Health Plans (QHP's) and stand-alone dental plans (SADPs),

The purpose of the network adequacy provisions of the federal Affordable Care Act is to assure the adequacy, accessibility, transparency and quality of health care services provided to covered individuals in individual and group market health insurance network plans. Pursuant to 45 C.F.R. 156.230(a)(2), a health carrier which issues a QHP or SADP that uses a provider network must "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay." All health carriers applying for QHP certification need to attest that they meet this standard as part of the certification/recertification process.

This provision applies to all health carriers in the individual market and to group plans. This provision applies to non-grandfathered group health plans.

**FAQs:** See the HHS website for guidance.

**NOTES:**

## STANDARDS NETWORK ADEQUACY

### Standard 1

**A health carrier offering individual and group market health insurance network plans shall maintain a network that is sufficient in number and types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons will be accessible, without unreasonable travel or delay.**

**Apply to:** All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

**Priority:** Essential

### Documents to be Reviewed

- \_\_\_\_\_ Health carrier policies and procedures related to network adequacy and plan design
- \_\_\_\_\_ Provider selection [tiering] criteria and supporting documentation regarding selection [tiering] criteria
- \_\_\_\_\_ Documents related to physician recruitment
- \_\_\_\_\_ Provider directory/listing
- \_\_\_\_\_ Health carrier policy/plan design for in network/out of network coverage levels
- \_\_\_\_\_ Provider/member location reports (e.g. by ZIP code)
- \_\_\_\_\_ List of providers by specialty
- \_\_\_\_\_ Any policies or incentives that restrict access to subsets of network specialists
- \_\_\_\_\_ Electronic tools used to assess the health carrier's network adequacy (e.g. GeoAccess®)
- \_\_\_\_\_ Complaint register/logs/files regarding inadequate networks and out of network service denials
- \_\_\_\_\_ Health carrier complaint records concerning network adequacy and plan design (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- \_\_\_\_\_ Health carrier marketing and sales policies and procedures' references to network adequacy and plan design

\_\_\_\_\_ Health carrier communication and educational materials related to network adequacy and plan design provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers

\_\_\_\_\_ Training materials

\_\_\_\_\_ Producer records

\_\_\_\_\_ Applicable state statutes, rules and regulations

Others Reviewed

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### **NAIC References**

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

### **Other References**

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

### **Review Procedures and Criteria**

Verify that the health carrier has established and implemented written policies and procedures regarding network adequacy and plan design of individual and group market health insurance health benefit network plans, in accordance with final regulations established by HHS, the DOL and the Treasury.

Review health carrier policies and procedures related to network adequacy and plan design to verify that the health carrier maintains a network that is sufficient in number and appropriate types of providers, including providers who 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, in compliance with final regulations established by HHS, the DOL and the Treasury.

Note: Examiners need to give particular attention to network sufficiency, marketing and disclosure in certain health carrier network plan designs, such as tiered, multi-tiered, layered or multi-level network plans, which include different access to benefits and cost-sharing based on a covered person's choice of provider. Examiners need to carefully review health carrier network filings to ensure that the network plan design is not potentially discriminatory for children and adults with serious, chronic or complex health conditions and that carriers will disclose information in a clear and conspicuous manner so that the covered person can understand the use of the tiered, multi-tiered, layered or multi-level network plan to access the benefits offered within the health benefit plan.

A state insurance commissioner determines network sufficiency in accordance with applicable state statutes, rules and regulations. Note: With regard to conflict of network adequacy provisions in state statutes, rules and regulations with final guidance on network adequacy set forth by HHS, the DOL and the Treasury, examiners may need to consult with state insurance department legal staff, regarding whether state provisions add to or create a more generous benefit than the network adequacy health reform requirements in final regulations established by HHS, the DOL and the Treasury, and are thus not preempted, as set forth in federal law.

Verify that the health carrier has established and implemented written policies and procedures 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 insurance commissioner of the applicable state, when:

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

Verify that the health carrier specifies and informs covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider when:

- The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and
- The health carrier:
  - 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
  - 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.

Verify that with regard to the process in which a covered person may use to request access to obtain a covered benefit from a non-participating provider, the health carrier addresses requests to obtain a covered benefit from a non-participating provider in a timely fashion appropriate to the covered person's condition. In order to determine what may be considered "in a timely fashion," examiners may wish to review the timeframes and notification requirements in applicable state statutes, rules and regulations regarding utilization review.

Verify that the health carrier treats the health care services the covered person receives from a non-participating provider 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.

Verify that the health carrier has a system in place that documents all requests to obtain a covered benefit from a non-participating provider and verify that the health carrier provides this information to the insurance commissioner of the applicable state upon request.

Note: Examiners need to be aware that the process which a covered person uses to request access to obtain a covered benefit from a non-participating provider is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with applicable state statutes, rules and regulations, nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options. A covered person is not precluded from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

Verify that the health carrier establishes and maintains adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the insurance commissioner of the applicable state may give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

Verify that the health carrier monitors, on an ongoing basis, the ability, clinical capacity and legal authority of its participating providers to furnish all contractual covered benefits to covered persons.

#### General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to network adequacy and plan design.

Review complaint records to verify that if the health carrier has not met minimum network adequacy standards or has improperly applied network adequacy standards, the health carrier has taken appropriate corrective action/adjustments regarding the removal of network adequacy limitations for the covered person(s) in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence supporting corrective action provided to a covered person, including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about network adequacy.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network adequacy.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to network adequacy.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to network adequacy.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network adequacy.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

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## STANDARDS NETWORK ADEQUACY

**Standard 2**

**A health carrier offering individual and group market health insurance network plans shall develop and file an access plan with the insurance commissioner in accordance with requirements regarding content and filing of network access plans set forth in applicable state statutes, rules and regulations.**

**Apply to:** All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Health carrier policies and procedures related to content of access plans

\_\_\_\_\_ Health carrier policies and procedures related to filing of access plans and material changes to access plans

\_\_\_\_\_ Copy of access plan filed in the applicable state and copy of access plan in use by health carrier

\_\_\_\_\_ Health carrier communication and educational materials related to access plans provided to applicants, enrollees, policyholders, certificate holders and beneficiaries, including communications with producers

\_\_\_\_\_ Training materials

\_\_\_\_\_ Producer records

\_\_\_\_\_ Applicable state statutes, rules and regulations

**Others Reviewed**

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**NAIC References**

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

## Other References

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

## Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding the health carrier's filing of access plans at the time it files a newly offered provider network, with the insurance commissioner of the applicable state, for individual and group market health insurance health benefit network plans, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that a health carrier files with the insurance commissioner of the applicable state for review (or for approval) prior to or at the time it files a newly offered network, in a manner and form defined by rule of the insurance commissioner, an access plan meeting the requirements of applicable state statutes, rules and regulations regarding network adequacy.

Note: Examiners need to be aware that requirements for access plans will vary by state. A state may require that a health carrier file access plans with the insurance commissioner of the applicable state for approval before use, or a state may require a health carrier to file access plans with the insurance commissioner for review, but permit the health carrier to use the access plan while it is subject to review. In addition, a health carrier may request an insurance commissioner to deem sections of an access plan as [proprietary, competitive or trade secret] information that shall not be made public. Verify that the health carrier makes access plans, absent [proprietary, competitive or trade secret] information, available online, at its business premises, and to any person upon request. Information is considered [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information. Applicable state statutes, rules and regulations should be reviewed to determine which term "proprietary," "competitive" or "trade secret" is being used in the applicable state.

Verify that when a health carrier prepares an access plan prior to offering a new network plan, the health carrier notifies the insurance commissioner of the applicable state of any material change to any existing network plan within fifteen (15) business days after the change occurs. Verify that the notice to the insurance commissioner provided by the health carrier includes a reasonable timeframe within which the health carrier will submit to the insurance commissioner, for approval or file with the insurance commissioner, as appropriate, an update to an existing access plan.

Note: Examiners need to be aware that the definition of "material change" will vary by state. For example, a "material change" may be a certain percentage change, as determined by a state, in the health carrier's network of providers or type of providers available in the network to provide health care services or specialty health care services to covered persons or it may be any change that renders the health carrier's network noncompliant with one or more network adequacy standards.

Verify that the health carrier's access plan describes or contains at least the following:

- The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable;
- The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

- The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;
- The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;
- The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of essential community providers (ECPs) in its network;
- The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
- The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:
  - The plan's grievance and appeals procedures;
  - Its process for choosing and changing providers;
  - Its process for updating its provider directories for each of its network plans;
  - A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and
  - Its procedures for covering and approving emergency, urgent and specialty care, if applicable (Note: Examiners need to be aware that a state may have an existing definition of "urgent" care in applicable state statutes, laws and regulations.)
- The health carrier's system for ensuring the coordination and continuity of care in situations where the health carrier, or its intermediary due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause:
  - For covered persons referred to specialty physicians; and
  - For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
- The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;
- The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at the health carrier's participating hospitals. (Note: Examiners need to be aware that if a limited scope dental and/or vision uses hospitals and/or other type of facility in its provider network, then the limited scope dental and/or vision plan shall comply with applicable state statutes, rules and regulations regarding network adequacy pertaining to hospitals and/or other type of facility); and
- Any other information required by the insurance commissioner of the applicable state to determine compliance with applicable state statutes, rules and regulations regarding network adequacy.

Note: Examiners need to be aware that for dental network plans, some states may not require the preparation and submission of a so-called “access plan” for purposes of determining the sufficiency of a dental provider network. These states may require other documentation to be included in the form filings to accomplish this purpose in order to review and determine the sufficiency of a dental and/or vision provider network. Examiners, however, need to be aware that dental carriers seeking certification to offer limited scope dental plans on a health insurance exchange or exchange use the term “access plan.”

#### General Review Procedures and Criteria

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about network access plans.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to network access plans.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to network access plans.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to network access plans.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

## STANDARDS NETWORK ADEQUACY

### Standard 3

**A health carrier’s contractual arrangements with participating providers shall comply with requirements regarding health carrier/participating provider contractual requirements set forth in applicable state statutes, rules and regulations.**

**Apply to:** All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

**Priority:** Essential

### Documents to be Reviewed

\_\_\_\_\_ Health carrier policies and procedures related to contractual arrangements between health carriers and participating providers

\_\_\_\_\_ Provider contracts

\_\_\_\_\_ Network plans

\_\_\_\_\_ Complaint register/logs/files relating to administrative, payment or other complaints/disputes made by participating providers relating to health carrier/participating provider contractual arrangements

\_\_\_\_\_ Health carrier complaint records concerning health carrier/participating provider contractual arrangements (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response/resolution)

\_\_\_\_\_ Health carrier communication and educational materials related to health carrier/participating provider contractual arrangements provided to participating providers

\_\_\_\_\_ Training materials

\_\_\_\_\_ Applicable state statutes, rules and regulations

### Others Reviewed

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## NAIC References

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

## Other References

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

## Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of individual and group market health insurance health benefit network plans with requirements relating to health carrier/participating provider contractual arrangements, in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier has established a mechanism by which a participating provider will be notified on an ongoing basis of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

Verify that contracts between a health carrier and a participating provider set forth a hold harmless provision specifying protection for covered persons. This requirement can be met by including a provision within the contract, substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier’s covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.”

Verify that contracts between the health carrier and a participating provider set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider’s obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

- The termination of the covered person’s coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled. (Note: Examiners need to be aware that the reference to termination may encompass all the circumstances in which a covered person’s coverage can be terminated, e.g. nonpayment of premium, fraud or intentional misrepresentation of material fact in connection with the coverage); or

- The date the contract between the health carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the health carrier or an intermediary had remained in operation.

Note: Examiners need to be aware that contractual arrangements between health carriers and providers that satisfy the above requirements (1) are to be construed in favor of the covered person, (2) shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and (3) shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions as set forth in the above standards relating to health carrier/provider contractual requirements. The hold harmless obligation does not apply to services rendered after the termination of the provider contract, except in the event that a network relationship is extended to provide continuity of care.

Verify that the participating provider does not collect or attempt to collect from a covered person any money owed to the provider by the health carrier. Review the contract provisions within the health carrier/participating provider contract with regard to periodic reconciliation/audit of itemized bills related to claims to health carrier reimbursement amounts. Review explanation of benefits (EOB) documents to verify that the provider is collecting the appropriate amount from the covered person.

Verify that the health carrier has developed, for providers and each health care professional specialty, selection standards for selecting and tiering, as applicable, of participating providers. Verify that the health carrier uses the selection standards in determining the selection [and tiering] of participating providers by the health carrier and its intermediaries with which it contracts. Verify that the selection standards meet the requirements of applicable state statutes, rules and regulations equivalent to the Health Care Professional Credentialing Verification Model Act.

Verify that the health carrier does not establish selection [and tiering] criteria in a manner:

- That would allow a health carrier to discriminate against high-risk populations by excluding [and tiering] providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health care services utilization; or
- That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health care services utilization.

Verify that the health carrier's selection criteria does not discriminate, with respect to participation under the health benefit plan, against any provider who is acting within the scope of the provider's license or certification under applicable state law or regulations. Note: Examiners need to be aware that a health carrier is not prohibited from declining to select a provider who fails to meet other legitimate selection criteria of the health carrier. The provisions of applicable state statutes, rules and regulations regarding network adequacy do not require a health carrier, its intermediaries or the provider networks with which they contract (1) to employ specific providers acting within the scope of their license or certification under applicable state law that may meet their selection criteria, or (2) to contract with or retain more providers acting within the scope of their license or certification under applicable state law than are necessary to maintain a sufficient provider network.

Verify that the health carrier makes its standards for selection and tiering, as applicable, of participating providers available for review [and approval] by the insurance commissioner of the applicable state.

Verify that a description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, is made available to the public.

Note: Examiners need to review how a health carrier markets or represents its network plans to consumers, particularly for those network plans that health carriers market or represent to consumers as using quality as at least one method of assessing whether to include providers in the network. In addition, for such network plans, examiners also need to review a health carrier's provider selection standards to ensure that quality is actually being used to assess whether to include providers in the network.

Verify that the health carrier notifies participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms; utilization review; quality assessment and improvement programs; credentialing; grievance and appeals procedures; data reporting requirements; reporting requirements for timely notice of changes in practice, such as discontinuance of accepting new patients; confidentiality requirements; and any applicable federal or state programs.

Verify that the health carrier does not offer an inducement to a provider that would encourage or otherwise incentivize the provider to deliver less than medically necessary services to a covered person.

Verify that the health carrier does not prohibit a participating provider from discussing any specific or all treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance or appeals processes established by the health carrier or a person contracting with the health carrier or in accordance with any rights or remedies available under applicable state or federal law.

Verify that contracts between a health carrier and a participating provider require the provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

Verify that the health carrier and participating provider provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause.

Verify that for providers who have asked to be removed from the network, the health carrier maintains and can provide examiners with such notices received from the provider.

With regard to providers who have been asked by the health carrier to no longer be part of the network, verify that the health carrier maintains and can provide to the examiner the notices it sent to the provider.

Verify that the health carrier makes a good faith effort to provide written notice of a provider's removal or leaving the network within thirty (30) days of receipt or issuance of a notice to all covered persons who are patients seen on a regular basis by the provider being removed or leaving the network, irrespective of whether it is for cause or without cause.



When a provider who is a primary care professional is being removed or is leaving the provider network, verify that the health carrier's contract with the participating provider requires the provider to provide the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

Verify that when a provider who is a primary care professional has been removed, or has left a provider network, the provider provides the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier. If the list is not provided to the health carrier by the primary care physician who has been removed or who has left a provider network, ascertain why the health carrier has not enforced the contractual provision regarding such notice.

Verify that when the provider being removed or leaving the network is a primary care professional, the health carrier provides notice to all covered persons who are patients of that primary care professional. .

When a covered person's provider leaves or is removed from the network, verify that the health carrier establishes reasonable procedures to transition a covered person who is in an active course of treatment to a participating provider in a manner that provides for continuity of care.

Verify that the health carrier makes available to the covered person a list of available participating providers in the same geographic area who are of the same provider type, and information about how the covered person may request continuity of care.

Verify that the health carrier's procedures outlining how a covered person may request continuity of care provide that:

- Any request for continuity of care can be made to the health carrier by the covered person or the covered person's authorized representative;
- Requests for continuity of care shall be reviewed by the health carrier's medical director after consultation with the treating provider for patients who meet the criteria "active course of treatment," "life-threatening health condition," and "serious acute condition" as defined in applicable state statutes, rules and regulations, and are under the care of a provider who has not been removed or leaving the network for cause. Any decisions made with respect to a request for continuity of care shall be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;
- The continuity of care period for covered persons who are in their second or third trimester of pregnancy shall extend through the postpartum period; and
- The continuity of care period for covered persons who are undergoing an active course of treatment shall extend to the earlier of:
  - The termination of the course of treatment by the covered person or the treating provider;
  - [Ninety (90) days] unless the health carrier's medical director determines that a longer period is necessary;
  - The date that care is successfully transitioned to a participating provider;
  - Benefit limitations under the plan are met or exceeded; or
  - Care is not medically necessary.

Note: Examiners need to be aware that while ninety (90) days is the current accreditation standard for the length of a continuity of care period, a state, when determining the length of time for the continuity of care period, may take into consideration the number of providers, especially specialty providers who are available to treat serious health conditions within the state.

- In addition to the above-referenced continuity of care provisions, a continuity of care request may only be granted when:
  - The provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to the health carrier for that patient as provided in the original provider contract; and
  - The provider agrees in writing not to seek any payment from the covered person for any amount for which the covered person would not have been responsible if the physician or provider were still a participating provider.

Review health carrier contractual arrangements with participating providers to verify that the rights and responsibilities under a contract between a health carrier and a participating provider are not assigned or delegated by either party without the prior written consent of the other party.

Verify that the health carrier has written policies and procedures in place to ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly-financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

Verify that the health carrier assumes responsibility for notifying participating providers (1) of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, and (2) of their obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

Verify that a health carrier does not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Verify that the health carrier has established a mechanism by which a participating provider may determine in a timely manner, at the time services are provided, whether or not an individual is a covered person or is within a grace period for payment of premium during which the health carrier may hold a claim for services rendered, pending receipt of payment of premium.

Verify that the health carrier has established written policies and procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

Review contractual arrangements between the health carrier and participating providers to ascertain if such contracts contain provisions that conflict with the provisions contained in the network plan and/or the requirements of applicable state statutes, rules and regulations regarding network adequacy.

Verify that, at the time a contract is signed, the health carrier and, if appropriate, an intermediary, notifies a participating provider, in a timely manner, of all provisions and other documents incorporated by reference into the contract. The language of the contract shall define what is to be considered timely notice.

Verify that, while a contract is in force, the health carrier notifies a participating provider in a timely manner, of any changes to those provisions or documents that would result in material changes in the contract. The language of the contract shall define what is to be considered timely notice and what is to be considered a material change.

Verify that a health carrier informs a provider of the provider's network participation status, in a timely manner, on any health benefit plan in which the health carrier has included the provider as a participating provider.

#### General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints/disputes made by participating providers relating to health carrier/participating provider contractual arrangements.

Review complaint/dispute records to verify that if the health carrier has not complied with the contractual provisions of, or fulfilled its obligations contained within the health carrier/participating provider contract, the health carrier has provided appropriate corrective action/adjustments to the participating provider(s) in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a participating provider.

Verify that health carrier communication and educational materials provided to participating providers provide complete and accurate information about health carrier/participating provider contractual arrangements.

Verify that the health carrier has established training programs designed to inform its employees about HHS, the DOL and the Treasury provisions and final regulations pertaining to health carrier/participating provider contractual arrangements.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to health carrier/participating provider contractual arrangements.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

## STANDARDS NETWORK ADEQUACY

### Standard 4

**A health carrier offering individual and group market health insurance network plans shall comply with requirements regarding balance billing in accordance with applicable state statutes, rules and regulations.**

**Apply to:** Health carriers issuing individual and group market health insurance network plans (ACA and non-ACA compliant)

**Priority:** Essential

### Documents to be Reviewed

- \_\_\_\_\_ Health carrier policyholder service policies and procedures related to balance billing
- \_\_\_\_\_ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.
- \_\_\_\_\_ Non-emergency out-of-network services written disclosures issued by facility-based providers
- \_\_\_\_\_ Out-of-network emergency services billing notices issued by facility-based providers
- \_\_\_\_\_ Non-participating facility-based provider-issued payment responsibility notices/billing statements
- \_\_\_\_\_ Health carrier's provider mediation process (policy and procedures)
- \_\_\_\_\_ Records of requests for provider mediation
- \_\_\_\_\_ Records of open and completed provider mediations
- \_\_\_\_\_ Complaint register/logs/files
- \_\_\_\_\_ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- \_\_\_\_\_ Health carrier communication and educational materials related to balance billing provided to applicants, enrollees, policyholders, certificateholders and beneficiaries
- \_\_\_\_\_ Training materials
- \_\_\_\_\_ Applicable state statutes, rules and regulations

## Others Reviewed

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**NAIC References**

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

**Review Procedures and Criteria**

Note: Examiners need to be aware that for purposes of this examination standard, “facility-based provider” means a provider who provides health care services to patients who are in an in-patient or ambulatory facility, including services such as pathology, anesthesiology, emergency room care, radiology or other services provided in an in-patient or ambulatory facility setting. These health care services are typically arranged by the facility by contract or agreement with the facility-based provider as part of the facility’s general business operations, and a covered person or the covered person’s health benefit plan generally does not specifically select or have a choice of providers from which to receive such services within the facility. Examiners need to review the applicable state’s definition of “facility-based provider” to make sure it includes any provider who may bill separately from the facility for health care services provided in an in-patient or ambulatory facility setting.

Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding compliance of individual and group market health insurance health benefit network plans with requirements set forth in applicable state statutes, rules and regulations regarding balance billing.

With regard to non-emergency out-of-network services, at the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision of non-emergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

- That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;
- That those facility-based providers may not have contracts with the covered person’s health carrier and are therefore considered to be out-of-network;
- That the service(s) therefore will be provided on an out-of-network basis;
- A description of the range of the charges for the out-of-network service(s) for which the covered person may be responsible;
- A notification that the covered person may either agree to accept and pay the charges for the out-of-network service(s), contact the covered person’s health carrier for additional assistance or rely on whatever other rights and remedies that may be available under state or federal law; and
- A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefit plan that are participating providers and that the covered person may request those participating facility-based providers.

At the time of admission in the participating facility where the non-emergency services are to be performed on the covered person, a facility shall provide a covered person with the written disclosure, as outlined above, and obtain the covered person's or the covered person's authorized representative's signature on the disclosure document acknowledging that the covered person received the disclosure document in advance prior to the time of admission.

With regard to out-of-network emergency services, a non-participating facility-based provider shall include a statement on any billing notice sent to a covered person for services provided, informing the covered person that he or she is responsible for paying their applicable in-network cost-sharing amount, but has no legal obligation to pay the remaining balance. Such statement also shall inform the covered person of his or her obligation to forward the bill to their health carrier for consideration under the provider mediation process described below if the difference in the billed charge and the plan's allowable amount is more than \$500.00. Note: Examiners need to be aware that the applicable dollar amount threshold may vary by state. A covered person is not precluded from agreeing to accept and pay the charges for the out-of-network service(s) and not using the provider mediation process described below.

In instances where a non-participating facility-based provider sends a billing notice directly to a covered person for the non-participating facility-based provider's service(s), the billing notice shall include the Payment Responsibility Notice below. The Payment Responsibility Notice shall state the following or substantially similar language:

“Payment Responsibility Notice – The service[s] outlined below was [were] performed by a facility-based provider who is a non-participating provider with your health care plan. At this time, you are responsible for paying your applicable cost-sharing obligation - copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have three choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference in the billed charge and the plan's allowable amount is more than [\$500.00], you may send the bill to your health care plan for processing pursuant to the health carrier's non-participating facility-based provider billing process or the provider mediation process required by applicable state statutes, rules and regulations; OR 3) you may rely on other rights and remedies that may be available in your state.”

Non-participating facility-based providers may not attempt to collect payment, excluding appropriate cost-sharing, from covered persons when the provider has elected to trigger the health carrier's non-participating facility-based provider billing process.

Non-participating facility-based providers who do not provide a covered person with a Payment Responsibility Notice, as outlined above, may not balance bill the covered person.

A covered person is not precluded from agreeing to accept and pay the bill received from the non-participating facility-based provider and not using the provider mediation process described below.

Regarding health carrier out-of-network facility-based provider payments:

- Health carriers shall develop a program for payment of non-participating facility-based provider bills;

- Health carriers may elect to pay non-participating facility-based provider bills as submitted or the health carrier may pay in accordance with the benchmark for non-participating facility-based provider payments established in applicable state statutes, rules and regulations;
- Non-participating facility-based providers who object to the payment(s) made in accordance with the above may elect the provider mediation process described in applicable state statutes, rules and regulations; and
- This section does not preclude a health carrier and an out-of-network facility-based provider from agreeing to a separate payment arrangement.

Payments to non-participating facility-based providers shall be presumed to be reasonable if a payment is based on the higher of the health carrier's contracted rate or [XX] percentage of the Medicare payment rate for the same or similar services in the same geographic area. Note: Examiners need to be aware that a state may use a percentage of the Medicare payment that a state considers appropriate. A state may alternatively use as a benchmark some percentage of a public, independent, database of charges for the same or similar services in the same geographic area; or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.

Verify that the health carrier has established a provider mediation process for payment of non-participating facility-based provider bills for providers objecting to the application of the established payment rate outlined in applicable state statutes, rules and regulations. The health carrier's provider mediation process shall be established in accordance with one of the following recognized mediation standards:

- The Uniform Mediation Act;
- Mediation.org, a division of the American Arbitration Association;
- The Association for Conflict Resolution (ACR);
- The American Bar Association Dispute Resolution Section; or
- The applicable state dispute resolution, mediation or arbitration section.

Verify that following completion of the provider mediation process, the cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider.

Verify that a health carrier provider mediation process is not used when the health carrier and the non-participating facility-based provider agree to a separate payment arrangement or when the covered person agrees to accept and pay the non-participating facility-based provider's charges for the out-of-network service(s).

Verify that a health carrier maintains records on all requests for mediation and completed mediations during a calendar year and, upon request, submits a report to the insurance commissioner of the applicable state in the format specified by the insurance commissioner.

The rights and remedies set forth in applicable state statutes, rules and regulations regarding balance billing shall be in addition to and may not preempt any other rights and remedies available to covered persons under state or federal law.

With regard to enforcement of state-specific requirements regarding balance billing, the appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general and the applicable state insurance department shall be responsible for enforcement of the requirements of applicable state statutes, rules and regulations pertaining to balance billing.

Note: Examiners need to be aware that state-specific requirements regarding balance billing shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by [insert the reference to applicable state law that defines long-term care insurance], vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the insurance commissioner of the applicable state by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Balance billing requirements do not apply to providers or covered persons using the process set forth in applicable state statutes, rules and regulations 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 makes other arrangements acceptable to the insurance commissioner of the applicable state.

The requirements set forth in applicable state statutes, rules and regulations regarding balance billing do not apply to facilities that have made arrangements with facility-based providers they employ or with whom they have contracts which prevent balance bills from being sent to persons covered by the same health benefit plans with which the facility contracts.

The insurance commissioner of the applicable state and the appropriate state agency with hospital/provider oversight, consumer protection division, or attorney general may, after notice and hearing, promulgate reasonable regulations to carry out the provisions set forth in applicable state statutes regarding balance billing. The regulations shall be subject to review in accordance with the applicable state statutory citation providing for administrative rulemaking and review of regulations.

#### General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to balance billing.

Review complaint records to verify that if a non-participating facility-based provider attempts to collect payment, excluding appropriate cost-sharing, from a covered person for health care services, the above reasons for noncompliance notwithstanding, the non-participating facility-based provider has taken appropriate corrective action/adjustments regarding the removal of the requirement of the covered person's payment for health care services, in a timely and accurate manner.

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.



Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to balance billing.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to balance billing.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

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## STANDARDS NETWORK ADEQUACY

**Standard 5**

**A health carrier offering individual and group market health insurance network plans shall develop and issue written disclosures or notices to be provided to covered persons regarding balance billing, in accordance with applicable state statutes, rules and regulations.**

**Apply to:** Health carriers issuing individual and group market health insurance network plans (ACA and non-ACA compliant)

**Priority:** Essential

**Documents to be Reviewed**

\_\_\_\_\_ Health carrier policyholder service policies and procedures related to written disclosures and notices of balance billing

\_\_\_\_\_ Policyholder service files and supporting documentation regarding balance billing, including letters, notices, telephone scripts, etc.

\_\_\_\_\_ Out-of-network services written disclosures provided by health carriers

\_\_\_\_\_ Non-emergency services written disclosures provided by facility-based providers

\_\_\_\_\_ Complaint register/logs/files

\_\_\_\_\_ Health carrier complaint records concerning balance billing (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

\_\_\_\_\_ Health carrier communication and educational materials related to written disclosures/notices of balance billing provided to applicants, enrollees, policyholders, certificateholders and beneficiaries

\_\_\_\_\_ Training materials

\_\_\_\_\_ Applicable state statutes, rules and regulations

**Others Reviewed**

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**NAIC References**

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

## **Review Procedures and Criteria**

Verify that the health carrier has established and implemented written policyholder service policies and procedures regarding the content and issuance of written disclosures or notices to covered persons regarding balance billing, in compliance with requirements set forth in applicable state statutes, rules and regulations.

Verify that the health carrier develops a written disclosure or notice to be provided to a covered person or the covered person's authorized representative at the time of pre-certification, if applicable, for a covered benefit to be provided at a facility that is in the covered person's health benefit plan network, that there is the possibility that the covered person could be treated by a health care professional that is not in the same network as the covered person's network.

Verify that the health carrier's disclosure or notice indicates that the covered person may be subject to higher cost-sharing, as described in the covered person's plan summary of coverage and benefits documents, including balance billing, if the covered services are performed by a health care professional, who is not in the covered person's plan network even though the covered person is receiving the covered services at a participating facility, and that information on what the covered person's plan will pay for the covered services provided by a non-participating health care professional is available on request from the health carrier. Verify that the disclosure or notice also informs the covered person or the covered person's authorized representative of options available to access covered services from a participating provider.

Verify that for non-emergency services, as a requirement of its provider contract with a health carrier, a facility develops a written disclosure or notice to be provided to a covered person of the carrier within ten (10) days of an appointment for in-patient or outpatient services at the facility or at the time of a non-emergency admission at the facility that confirms that the facility is a participating provider of the covered person's network plan and informs the covered person that a health care professional, such as an anesthesiologist, pathologist or radiologist, who may provide services to the covered person while at the facility may not be a participating provider in the same network as the covered person's network.

### General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to content and issuance of written notices or disclosures regarding balance billing.

Review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable state statutes, rules and regulations, has improperly issued such notice or has not issued such notice, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper written notice or disclosure to the covered person(s).

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about content and issuance of written notices or disclosures pertaining to balance billing.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations regarding content and issuance of written notices or disclosures pertaining to balance billing.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to content and issuance of written notices or disclosures pertaining to balance billing.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law.

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## STANDARDS NETWORK ADEQUACY

### Standard 6

**A health carrier offering individual and group market health insurance network plans shall comply with requirements set forth in applicable state statutes, rules and regulations regarding content, accessibility, transparency, accuracy, and completeness of printed and electronic provider directories.**

**Apply to:** All individual and group health products (non-grandfathered products) for policy years and plan years beginning on or after Jan. 1, 2014

This standard does not apply to grandfathered health plans in accordance with §147.140

This standard does not apply to transitional plans

**Priority:** Essential

### Documents to be Reviewed

- \_\_\_\_\_ Health carrier policies and procedures related to provider directories
- \_\_\_\_\_ Files and supporting documentation regarding frequency of provider directory revisions and updates
- \_\_\_\_\_ Provider directory (print copy provided to covered persons)
- \_\_\_\_\_ Web-based provider directory
- \_\_\_\_\_ Health carrier self-audit of provider directory
- \_\_\_\_\_ Complaint register/logs/files regarding inaccessibility, inaccuracy and incompleteness of provider directories
- \_\_\_\_\_ Health carrier complaint records concerning provider directories (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)
- \_\_\_\_\_ Health carrier marketing and sales policies and procedures' references to provider directories
- \_\_\_\_\_ Health carrier communication and educational materials related to provider directories provided to applicants, enrollees, policyholders, certificateholders and beneficiaries, including communications with producers
- \_\_\_\_\_ Training materials
- \_\_\_\_\_ Producer records

\_\_\_\_\_ Applicable state statutes, rules and regulations

Others Reviewed

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### NAIC References

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

### Other References

\_\_\_\_\_ HHS/DOL/Treasury final regulations, to include FAQs and other federal resource materials

### Review Procedures and Criteria

Verify that the health carrier has established and implemented written policies and procedures regarding compliance of individual and group market health insurance health benefit network plans with provider directory requirements in accordance with final regulations established by HHS, the DOL and the Treasury.

Verify that the health carrier posts electronically a current and accurate provider directory for each of its network plans, to include the following information in a searchable format:

- For health care professionals:
  - Name;
  - Gender;
  - Participating office location(s);
  - Specialty, if applicable;
  - Medical group affiliations, if applicable;
  - Facility affiliations, if applicable;
  - Participating facility affiliations, if applicable;
  - Languages spoken other than English, if applicable; and
  - Whether accepting new patients.
- For hospitals:
  - Hospital name;
  - Hospital type (i.e. acute, rehabilitation, children's, cancer);
  - Participating hospital location; and
  - Hospital accreditation status; and
- For facilities, other than hospitals, by type:
  - Facility name;
  - Facility type;
  - Types of services performed; and
  - Participating facility location(s).

In addition, for electronic provider directories, for each network plan, verify that the health carrier makes available the following information in addition to all of the information above:

- For health care professionals:
  - Contact information;
  - Board certification(s); and
  - Languages spoken other than English by clinical staff, if applicable.
- For hospitals: telephone number; and
- For facilities other than hospitals: telephone number.

Verify that in making the directory available electronically, the health carrier ensures that the general public is able to view all of the current providers for a plan via a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

Verify that the health carrier updates each network plan provider directory at least monthly.

Verify that the health carrier periodically audits at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the insurance commissioner of the applicable state upon request.

Verify that the health carrier provides a print copy, or a print copy of the requested directory information, of a current provider directory with the information listed below, upon request of a covered person or a prospective covered person.

- For health care professionals:
  - Name;
  - Gender;
  - Participating office location(s);
  - Specialty, if applicable;
  - Medical group affiliations, if applicable;
  - Facility affiliations, if applicable;
  - Participating facility affiliations, if applicable;
  - Languages spoken other than English, if applicable; and
  - Whether accepting new patients.
- For hospitals:
  - Hospital name;
  - Hospital type (i.e. acute, rehabilitation, children's, cancer);
  - Participating hospital location; and
  - Hospital accreditation status; and
- For facilities, other than hospitals, by type:
  - Facility name;
  - Facility type;
  - Types of services performed; and
  - Participating facility location(s).

Verify that for each network plan, a health carrier includes in plain language in both the electronic and print directory, the following general information:

- In plain language, a description of the criteria the health carrier has used to build its provider network;
- If applicable, in plain language, a description of the criteria the health carrier has used to tier providers;
- If applicable, in plain language, how the health carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier; and
- If applicable, note that authorization or referral may be required to access some providers.

Verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

Verify that the health carrier includes in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

Verify that for all of the pieces of information required to be included in a printed or electronic provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier makes available through the directory the source of the information and any limitations, if applicable.

Verify that the health carrier's provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency.

Verify that the health carrier makes available in print, upon request, the following provider directory information for the applicable network plan:

- For health care professionals:
  - Name;
  - Contact information;
  - Participating office location(s);
  - Specialty, if applicable;
  - Languages spoken other than English, if applicable; and
  - Whether accepting new patients.
- For hospitals:
  - Hospital name;
  - Hospital type (i.e. acute, rehabilitation, children's, cancer); and
  - Participating hospital location and telephone number; and
- For facilities, other than hospitals, by type:
  - Facility name;
  - Facility type;
  - Types of services performed; and
  - Participating facility location(s) and telephone number.



Verify that the health carrier includes a disclosure in the printed directory that the information included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the health carrier's electronic provider directory on its website or call the health carrier's customer service telephone number to obtain current provider directory information.

#### General Review Procedures and Criteria

Review complaint register/logs and complaint files to identify complaints pertaining to inaccessibility, inaccuracy and incompleteness of provider directories.

Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable state statutes, rules and regulations, has improperly issued such a directory or has not issued such a directory, the health carrier has taken appropriate corrective action/adjustments regarding the issuance of a proper provider directory to covered person(s).

Ascertain if the health carrier error could have been the result of some systemic issue (e.g., programming or processing error). If so, determine if the health carrier implemented appropriate corrective actions/adjustments to its systems in a timely and accurate manner. The examiner should include this information in the examination report.

Verify that the health carrier maintains proper documentation for correspondence, supporting corrective action provided to a covered person(s), including website notifications.

Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that health carrier communication and educational materials provided to applicants, enrollees, policyholders, certificateholders and beneficiaries provide complete and accurate information about content, accessibility, transparency, accuracy, and completeness of provider directories.

Verify that the health carrier has established training programs designed to inform its employees and producers about HHS, the DOL and the Treasury provisions and final regulations pertaining to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review health carrier training materials to verify that information provided therein is complete and accurate with regard to content, accessibility, transparency, accuracy, and completeness of provider directories.

Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/proposed insureds is complete and accurate with regard to content, accessibility, transparency, accuracy, and completeness of provider directories.

Note: With regard to conflict of state and federal law, examiners may need to review and base examinations upon applicable state statutes, rules and regulations, especially where state statutes, rules and regulations add state-specific requirements to the health reform requirements or create a more generous benefit, and thus not preempted, as set forth in federal law. G:\MKTREG\DATA\D Working Groups\D WG 2016 MCES (PCW)\Docs\_WG Calls 2016\Network Adequacy\Current Exposure Draft\Network Adequacy Exam Standards 4-26-16.docx

To: Director Bruce R. Ramage, Chairman, Market Conduct Examination Standards (D)  
Working Group  
Cc: Petra Wallace, Market Regulation Specialist  
From: Undersigned Consumer Representatives to the NAIC  
Date: May 27, 2016  
**RE: Draft Network Adequacy Examination Standards for Inclusion in *Market Regulation Handbook***

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We appreciate the opportunity to comment on the draft Network Adequacy Examination Standards for inclusion in the NAIC's *Market Regulation Handbook*. We agree that the current Network Adequacy Examination Standards, which were based on the NAIC's 1996 version of the Managed Care Plan Network Adequacy Model Act, do need to be updated to reflect both the updates that the NAIC recently made to its Network Adequacy Model Act #74 as well as federal Affordable Care Act requirements. We strongly support the development and adoption of each of the six proposed Exam Standards and make the following recommendations for improving upon them.

### **Overall Comments**

We recognize from the outset that updating these Exam Standards is complicated. Although only a few states had adopted the NAIC's 1996 Model Act in a substantially similar manner, many states have adopted pieces of the Model Act. However, state laws vary as to the scope of their requirements and the type of plans they cover. For example, according to a 2014 survey of state insurance departments, 45 percent of states that responded said that they require GEO Access maps or their equivalent for HMO plans, while only 29% of states have such requirements for PPOs. Numerous states have also adopted network adequacy consumer protections in other areas, such as provider directory requirements, balance billing protections, and continuity of care provisions. Since the NAIC adopted its updated version of the Network Adequacy Model Act in November, we have seen a renewed interest in the part of states in adopting the model in whole or in parts.

In those states that have adopted the NAIC's Health Benefit Plan Network Access and Adequacy Model Act or similar, the requirements generally apply to all carriers that offer individual or group plans that use a provider network, including limited scope dental and vision plans. Grandfathered and transitional plans that use provider networks are also subject to state network adequacy requirements, unless states have explicitly exempted them.

As an overlay to state requirements, the ACA requirements for network adequacy, established under section 1311(c)(1)(B) of the ACA, apply only to qualified health plans (QHPs) and stand-alone dental plans (SADPs) and not to all individual and group health products. In addition, CMS has established additional network adequacy requirements that apply to QHPs in federally-facilitated marketplace (FFM) states through its annual "Letter to Issuers in the Federally-Facilitated Marketplaces".

Given that exam standards are generally intended to guide examiners in ensuring compliance with both federal and state laws and regulations, we generally recommend that the draft Network

Adequacy Exam Standards be revised to reflect where state laws and regulations may also govern network adequacy and to clarify which federal requirements apply only to QHPs or FFM QHPs. Therefore, we make the following recommendations:

- On page 1, in the “Provision” section, we recommend revising the sentence to read: “The provisions of the federal Affordable Care Act (ACA) established a requirement that a health carrier offering a qualified health plan (QHP) or a stand-alone dental plan (SADP) must meet minimum criteria for adequacy of provider networks delivering all covered services and access to its provider directory. Additionally, in states that have adopted the NAIC’s Health Benefit Plan Network Access and Adequacy Model Act or substantially similar laws or regulations, health carriers offering health insurance coverage in the individual or group markets providing a network plan in a state must meet standards for assuring the adequacy, accessibility, transparency and quality of health care services offered under the network plan.”
- On page 1, the “Background” section should be similarly revised to reflect that both federal law, regulations and guidance and state laws and regulations governing network adequacy set forth requirements for assuring access to covered services, as applicable. We would be glad to work with the Working Group to revise the Background section.
- For each Exam Standard, in the “Apply To” section, we recommend the following:
  - Change the first sentence to read: “In states that have adopted the NAIC’s Health Benefit Plan Network Access and Adequacy Model Act (#74) or substantially similar provisions, all individual and group health products.”
  - Delete the sentences that say this standard does not apply to grandfathered or transitional plans.
  - The Working Group may wish to add a sentence such as the following: “Portions of this standard apply only to qualified health plans (QHPs) that use a provider network or to such QHPs in federally-facilitated marketplaces (FFM), as specifically noted.”
- For each Exam Standard, in the “Documents to be Reviewed” section, we recommend adding at the end of the “Complaint register/logs/files” bullet the following: “(including complaint records maintained by other state or federal agencies, if applicable)”
- For each Exam Standard, in the “Other References” section, we recommend revising to read:

\_\_\_ HHS final regulations and guidance, to include annual “Letter to Issuers in Federally-Facilitated Marketplaces,” FAQs and other federal resource materials

We make this recommendation because most of the regulations and guidance pertaining to network adequacy for QHPs are issued only by HHS, not by the Tri-Agencies.

In addition to these general changes to be made throughout the Exam Standards, we make the following specific recommendations with respect to each standard:

## **Standard 1**

- In the box at the top of page 2, add a sentence at the end as follows: “Covered persons shall have access to emergency services twenty-four (24) hours per day, seven (7) days per week.”
- Add to the list of “Documents to be Reviewed”:
  - \_\_\_ Health carrier network access plan
  - \_\_\_ Health carrier documentation of requests from covered persons to obtain out-of-network care at in-network level of benefits
- On page 3, under “Review Procedures and Criteria,” add at the end of the 2<sup>nd</sup> paragraph: “Review health carrier policies and procedures related to network adequacy and plan design to verify that covered persons will have access to emergency services twenty-four (24) hours per day, seven (7) days per week.”
- At the top of page 4, we recommend revising the first sentence to read: “A state insurance commissioner determines network sufficiency in accordance with applicable state statutes, rules and regulations, including use of quantitative standards, where applicable.”
- Add the following on page 4: “When reviewing QHPs in an FFM state, examiners should verify that these plans provide reasonable access to certain specialties using the maximum time and distance standards detailed by CMS in its annual Letter to Issuers in the FFMs.”
- On page 4, we recommend adding the following: “Note: When reviewing non-grandfathered large group or self-insured group health plans that use a reference-based pricing or similar network design, examiners should give careful attention to whether the plan treats providers that accept the reference-based price as the only in-network providers and excludes or limits cost-sharing for services rendered by other providers as applied toward maximum out-of-pocket limit if it exceeds the reference based price for the service and if so, whether the plan is using a reasonable method to ensure adequate access to quality providers at the reference price, per Frequently Asked Questions (FAQ) guidance issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor, and the U.S. Department of the Treasury. FAQ XXI in particular lays out criteria that examiners should review when determining whether a plan is using a reasonable method to ensure adequate access to providers at the reference price.<sup>1</sup>”
- Throughout this Exam Standard, wherever language referencing the federal regulations established by HHS, the DOL, and Treasury are referenced, the language should be revised to instead reference “state laws, regulations, and guidance and final regulations and guidance established by HHS or HHS, DOL, and Treasury”.

## **Standard 2**

- On page 8, in the Note, we recommend starting a new paragraph beginning at: “Verify that the health carrier makes access plans...” We also recommend deleting the following sentence since it is not included in the NAIC’s Network Adequacy Model Act: “Information is

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<sup>1</sup> See FAQ XIX (<https://www.dol.gov/ebsa/faqs/faq-aca19.html>) and FAQ XXI (<https://www.dol.gov/ebsa/faqs/faq-aca21.html>) for more information.

considered [proprietary or competitive or a trade secret] if revealing the information would cause the health carrier's competitors to obtain valuable business information."

- On page 9, after the 3<sup>rd</sup> bullet, we recommend adding the following new note: "Note: Examiners should be aware that federal law, regulations, and guidance require that an issuer offering a QHP have a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHPs service area. In addition, some states have established their own more protective requirements for ensuring the inclusion of ECPs in QHPs and other health plans."
- On page 9, the 6<sup>th</sup> bullet should be revised to read: "The health carrier's system for ensuring the coordination and continuity of care:" [In other words, the following text should be deleted because it is not included in Subsection 5F of the NAIC's Network Adequacy Model Act on which this bullet is based: "in situations where the health carrier, or its intermediary due to insolvency or other cessation of operations, and when a participating provider is being removed or leaving the network with or without cause". The access plan requirements in Subsection 5F for ensuring the coordination and continuity of care are not intended to be limited to only these situations.]
- On page 10, under "General Review Procedures and Criteria", at the end of the first bullet add at the end: "and that access plans are available to the public online, at the carrier's business premises and upon request."
- On page 10, under "General Review Procedures and Criteria", add a new paragraph that reads: "Verify that the information included in the access plan is consistent with information otherwise made available to applicants and enrollees through marketing and educational materials and to employees and producers through training materials and communications."
- Throughout this Exam Standard (specifically page 8 and 10) where reference is made to access plans, references to final regulations established by HHS, the DOL and the Treasury should instead be revised to reference "state laws, regulations, and guidance." As a general matter, access plans are not required as part of federal network adequacy regulations and guidance but are instead required by states.

### **Standard 3**

- On page 11, under "Documents to be Reviewed," we recommend revising "Provider contracts" to read "Health carrier contracts with providers".
- On page 11, under "Documents to be Reviewed," we recommend revising "Network plans" to read "Health carrier network access plans".
- On page 15, we recommend revising the 1st sentence in the 2<sup>nd</sup> bullet under the paragraph about verifying continuity of care requests to read: "Requests for continuity of care shall be reviewed by the health carrier's medical director after consultation with the treating provider for patients who meet the criteria of being in the midst of an "active course of treatment" for a "life-threatening health condition," for a "serious acute condition," for the

second or third trimester of pregnancy, or for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.”

- At the top of page 16, we recommend adding an additional note, as follows: “**Note:** Examiners should be aware that many states that have not adopted the NAIC’s Model Act in whole have adopted their own continuity of care provisions that may differ from or exceed the NAIC or federal requirements. Examiners should review the requirements in their state. In addition, particularly in states without their own continuity of care provisions, examiners should also be aware that federal regulations provide for continuity of care for patients enrolled in QHPs in a FFM state, effective for the 2017 plan year. These federal provisions are substantially similar to the continuity of care provisions in Subsection 6L of the NAIC’s Network Adequacy Model Act. To review the federal requirements, examiners should see CFR § 156.230(d) and related guidance.”
- On page 17, in the 2<sup>nd</sup> paragraph, we recommend adding the following language at the end of the 2<sup>nd</sup> sentence: “...**except that retroactive application of a change in the contract or in a document incorporated by reference is not considered timely notice.**” This language comes from the drafting note explaining the intent behind Subparagraph 6T of the NAIC’s Network Adequacy Model Act.
- Throughout this Exam Standard, where either state statutes, rules or regulations or HHS/DOL/Treasury rules or regulations are referenced, we recommend that the language be revised to instead reference both “**applicable state statutes, rules and regulations, and guidance and final HHS regulations and guidance regarding network adequacy.**”

#### **Standard 4**

**Documents to Review:** We support the documents listed to review. Some of the documents currently listed may depend on individual state laws. If state law requires issuers to maintain a mediation process for balance bills, examiners should review the following documents:

- Health carrier’s provider mediation process (policy and procedures)
- Records of requests for provider mediation
- Records of open and completed provider mediations

However, other states may establish different structures for balance bill mediation processes. In those states, documents regarding the health carrier’s provider mediation process would not be applicable but the records regarding mediation would.

Some states may not require mediation for balance bills at all; in those states no documents regarding mediation may be applicable. Therefore, the NAIC may need to consider listing the above three documents on the list as “**if applicable.**”

Requirements for providers to issue notices to consumers vary within states that have laws or rules pertaining to balance billing. In states where insurance regulators do not have authority over providers, examiners may need to coordinate with the Department of Health or other

appropriate state agencies to obtain these documents and to ensure compliance with state laws and regulations. **These documents too may need to be listed as “if applicable” since their availability will depend on state law:**

- Non-emergency out-of-network services written disclosures issued by facility-based providers
- Out-of-network emergency services billing notices issued by facility-based providers
- Non-participating facility-based provider-issued payment responsibility notices/ billing statements

### Review Procedures and Criteria

- On page 19 the definition of a “facility-based provider” as included in the NAIC Network Adequacy Model Act is provided. While states may adopt this definition, some may use a different definition, and some states may apply balance billing rules to different sets of providers. Therefore, the note should indicate that examiners should ensure they understand to which providers their state applies any balance billing rules.  
**Recommendation:** Remove: “examiners need to review the applicable state’s definition of “facility-based provider” to make sure it includes any provider who may bill separately from the facility for health care services provided in an in-patient or ambulatory facility setting.” Instead we recommend adding, “**Examiners must review whether the state applies balance billing rules to facility-based providers as defined here or to a broader or narrower range of providers.**”
- On page 19-20 the following notices are outlined in detail: 1) non-emergency out-of-network service notices that facilities must provide when a facility schedules a procedure or seeks prior authorization; 2) out-of-network emergency service notices indicating that patients are not responsible for costs beyond in-network cost-sharing; and 3) Payment Responsibility Notice (including a description of a \$500 minimum threshold for a mediation process).  
Whether these notices (and the consumer payment policies underlying them) are required, and whether mediation for bills over a certain threshold is available depends on state law. To our knowledge, currently only one state (Texas) limits its mediation process to bills that exceed a minimum dollar threshold.  
**Insert:** Note to examiner: State laws, regulations, and rules may vary on whether notices from providers about non-emergency out-of-network services and out-of-network emergency services regarding balance billing are required. Furthermore, the content of these notices may vary based on state laws, regulations, and rules regarding consumers’ financial recourse for balance bills. Examiners should identify this state’s specific requirements, if any, for provider notices.
- Page 21: Insert: Note to examiner: Whether states have mediation or arbitration processes to resolve balance bills varies based on state laws, regulations or rules. The same is true

regarding whether the state has a specific formula for determining reasonable payments to non-contracting providers for use in these processes. These standards describe the formula in the NAIC network adequacy model; states may rely on other methods. In states where a mediation or arbitration process is used, the examiner should identify the specific method used.

- P.21: Replace the section starting with “Verify that the health carrier has established a provider mediation process...” with “**Verify that the health carrier complies with any state laws regarding mediation or arbitration processes for payment of non-participating provider bills.**”
- P. 21 Edit as follows: “Verify that following completion of ~~the~~ **any state-required** provider mediation process, ~~the~~ **cost of mediation shall be split evenly and paid by the health carrier and the non-participating facility-based provider or the carrier otherwise follows any state requirements regarding their share of the cost for the process.**”
- P. 22 Insert: “**If applicable based on state law**, review complaint records **(including complaint records to other state agencies, if applicable)** to verify that if a non-participating facility-based provider attempts to collect payment...”
- P. 23: Edit as follows to account for balance billing requirements primarily being included in state standards: “Verify that the health carrier has established training programs designed to inform its employees and producers about **state laws and regulations and final regulations and guidance established by HHS, the DOL and the Treasury provisions and final** pertaining to balance billing.”

### **Standard 5**

- P. 24: We recommend adding reference to federal requirements at the end of its description as follows: *... in accordance with applicable **federal** and state statutes, rules and regulations.*

### **Documents to Be Reviewed**

- P. 24: Insert: Non-emergency services written disclosures provided by facility-based providers, *if applicable*

### **Review Procedures and Criteria**

- P. 25: Insert: In accordance with federal rules, for the 2018 plan year and on, verify that the health carrier develops a written notice to be provided to covered persons by the longer of when the carrier would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit. The notice must state that additional costs may be incurred for an essential health benefit provided by an out-of-network ancillary provider (defined by HHS) in an in-network setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.



[Note to examiner: “HHS defines an ancillary provider as: the provider of a service ancillary to what is being provided by the primary provider, such as anesthesiology or radiology) rather than the services supplied by the primary provider.”]

- P. 25: Insert: **If applicable based on requirements set forth in applicable state statutes, rules, and regulations**, verify that the health carrier develops a written disclosure or notice to be provided...[Note to examiner: **Identify whether state laws require notices to be provided to covered persons receiving services and/or getting care from providers not included in federal notice requirements.**]
- P.25: Insert: **If applicable based on requirements set forth in applicable state statutes, rules, and regulations**, verify that the health carrier’s disclosure or notice indicates that... [Note to examiner: **Identify whether state law requires notices with this content to be provided to covered persons receiving services and/or getting care from providers not included in federal notice requirements.**]
- P. 25: Insert: **Verify that for the 2018 plan year and beyond the health carrier has established processes to count the cost-sharing paid by a covered person for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee’s annual limitation on cost sharing in instances in which the carrier fails to provide the notice described above to the covered person, in accordance with federal regulations.**

#### **General Review Procedures and Criteria**

- P. 25: Insert: Review complaint register/ logs and complaint files to identify complaints pertaining to receipt of balance bills; ascertain if complainants received notices.
- P. 25: Insert: review complaint records to verify that if the health carrier has issued a written notice or disclosure of balance billing not in compliance with the content requirements of applicable **federal or** state statutes, rule and regulations...
- P. 26: Insert (like Standard 4): “Verify that the health carrier has established training programs designed to inform its employees and producers about **state laws, regulations, and guidance and final regulations and guidance established by HHS, the DOL and the Treasury provisions and final** pertaining to balance billing.”

#### **Standard 6**

- P. 27: We recommend inserting the following language to account for federal requirements in the description: “...*requirements set forth in applicable state and **federal** statutes, rules and regulations...*”
- P. 27: As mentioned in our overarching comments, state laws generally apply provider directory standards to all state-regulated products and therefore the “apply” to section should be edited to reflect that.

## Documents to be Reviewed

- P. 27: Insert: Health carrier marketing and sales policies and procedures' references to provider directories **and provider networks**
- P. 27: Insert: Health carrier communication and education materials related to provider directories **and provider networks** provided to applicants, enrollees, policyholders, certificate-holders and beneficiaries, including communications with producers

## Review Procedures and Criteria

- P. 28: Delete references to DOL and the Treasury.
- P. 28: Insert: Verify that, in accordance with federal regulations, qualified health plans make their provider directories available to potential enrollees in hard copy upon request. QHPs must also make this information available to the Exchange for publication online. Verify that this information is current, accurate, and complete:
  - which providers are accepting new patients,
  - the provider's location,
  - contact information,
  - specialty,
  - medical group, and
  - any institutional affiliations.
- P. 28: Insert: **Verify that for QHP issuers, if a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.** If applicable under state law, verify that the health carrier makes it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state. [Second half moved up from p. 30]  
[Note to examiner: State law may extend these requirements beyond qualified health plans. A QHP issuer in a federally-facilitated Exchange must also make available the information described above on its Web site in an HHS specified format and also submit this information to HHS, in a format and manner and at times determined by HHS, for purposes of enabling machine-readable provider directories. HHS will also label each QHP network's breadth as basic, standard, or broad compared to other QHP networks on HealthCare.gov starting for plan year 2017.]
- P. 28: Insert: **As applicable under state law,** verify that the health carrier posts electronically...

[Note to examiner: Identify whether state law requires carriers to include additional elements beyond those required under federal regulations in provider directories, and whether state requirements apply such standards to a broader range of plans beyond qualified health plans.]

- P. 29: Insert: Verify that the health carrier updates each network plan provider directory at least monthly or **within the specified timeframe stated under applicable state law, regulations, or rules.**  
[Note to examiner: Federal regulations and guidance require qualified health plans to update directories monthly.]
- P. 29: Insert: Verify that the health carrier periodically audits at least a reasonable sample of its provider directories for accuracy and retains documentation of such an audit to be made available to the insurance commissioner of the applicable state upon request **or complies with any other provider directory audit and corresponding directory modification requirements as applicable under state law.**
- p. 29: Insert: “Verify that the health carrier provides a print copy, or a print copy of the request directory information.... upon request of a covered person or a prospective covered person **in accordance with state law.**”
- p. 30: Insert: Verify for that each network plan, **as applicable under state and federal laws, regulations, and rules,** a health carrier includes in plain language...
  - If applicable, in plain language, how the health carrier designates the different provider tiers or levels in the network and **verify that the carrier** identifies for each specific provider, hospital, or other type of facility in network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier.  
[Note to examiners: federal guidance requires for qualified health plans that, “if the health plan issuer maintains multiple provider networks, the plans and provider network(s) associated with each provider, *including the tier in which the provider is included,* should be clearly identified on the website and in the provider directory.]
- P. 30: Insert: Verify that the carrier’s provider directory, whether in electronic or print format, accommodates the communication needs of individuals with disabilities, and includes a link to or information regarding available assistance for persons with limited English proficiency, **as applicable under state law. For qualified health plan issuers, verify that the carrier’s online and print directories comply with HHS tagline requirements (or stronger state requirements, where applicable) under 45 CFR 155.205 that indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State, as determined in guidance published by the Secretary, beginning for the 2017 plan year. For the issuers’ online directories, verify that the carrier’s online directory complies with HHS requirements for translation into any non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.**
- P. 30: Insert: Verify that the health carrier makes available in print, upon request, the following provider directory information for the applicable network plan, **in accordance with state law:**

- P. 31: Insert: Review complaint records to verify that if the health carrier has issued a provider directory not in compliance with the content requirements of applicable **federal** and state statutes...
- P. 31: Insert: Verify that any marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about **the network, based on evaluation of the** content, accessibility, transparency, accuracy, and completeness of provider directories.
- P 31: Insert: Verify that health carrier communication and education materials provided to applicants, enrollees, policyholders, certificate-holders, and beneficiaries provide complete and accurate information about **the network based on evaluation of the** content, accessibility, transparency, accuracy, and completeness of provider directories.
- P. 31: Remove reference to DOL and the Treasury, insert reference to “state laws, regulations, and rules” regarding training programs for employees and producers.
- P. 31: Insert: For health carrier training materials, insert, “complete and accurate with regard to **requirements for** content accessibility, transparency, accuracy, and completeness of provider directories.
- P. 31: Insert: Review producer records and health carrier communication with producers to verify that information provided by producers to applicants/ proposed insured is complete and accurate with regard to ~~content, accessibility, transparency, accuracy, and completeness of provider~~ **networks** directories.

Thank you for your consideration of our comments. We look forward to working with the Working Group to finalize these Exam Standards.

Sincerely,  
Stephanie Mohl  
Claire McAndrew  
Timothy Jost  
Lincoln Nehring  
Adrienne Ellis  
Cynthia Zeldin  
Bailey Acevedo  
Deborah Darcy  
Andrew Sperling  
Roy S. Mitchell  
Sarah Lueck  
Anna Howard

Jackson Williams  
India R. Hayes Larrier  
Bonnie Burns  
Debra Judy  
Angela Lello  
Elizabeth Abbott  
Pam Silberman  
Elizabeth Imholz  
Jesse Ellis O’Brien  
JoAnn Volk  
Silvia Yee

*Conference Calls*

**STANDARDIZED DATA REQUEST (D) SUBGROUP**

**June 1, 2016 / May 11, 2016**

**Summary Report**

The Standardized Data Request (D) Subgroup met June 1 and May 11, 2016. The meetings were held in regulator-to-regulator session pursuant to paragraph 6 (consultations with NAIC staff members related to NAIC technical guidance) of the NAIC Policy Statement on Open Meetings. During these meetings, the Subgroup:

1. Discussed potential updates to the Commission section and the Producer Codes section of the producer, commission and complaint standardized data request.
2. The Subgroup will next meet in late June and will finalize its review of the producer, commission and complaint standardized data request at that time. The next standardized data request that the Subgroup will begin working on is the life and annuity insurance data request.

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