PROJECT HISTORY - 2015

MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT (#74)

1. Description of the Project, Issues Addressed, etc.

In 2013, the Regulatory Framework (B) Task Force was charged to review NAIC existing models related to health insurance to determine whether they needed to be amended in light of all the changes made by the federal Affordable Care Act (ACA). During that review process, it was clear that revising the *Managed Care Plan Network Adequacy Model Act* (#74) was a priority for regulators, carriers and consumers. In addition, revising Model #74 became even more of a priority because of the concern that the federal Center for Consumer Information and Insurance Oversight (CCIIO) was, and still is, considering adopting regulations to establish federal network adequacy standards; i.e., a possible "one-size-fits-all" national standard. A federal one-size-fits-all national standard would not benefit consumers or health carriers. State insurance regulators are best positioned to balance cost, access and geographic considerations when developing network adequacy standards to ensure networks are sufficient so that consumers can access promised services without unreasonable delay.

In March 2014, the Regulatory Framework (B) Task Force established the Network Adequacy Model Review (B) Subgroup, with Wisconsin as chair, to begin working on revising Model #74. In May 2014, the Subgroup began weekly calls—which became twice weekly calls—to receive input from various interested groups and consider possible revisions to Model #74. In November 2014, the Subgroup released an initial draft of proposed revisions to Model #74 with a Jan. 12, 2015, comment deadline. In response to the Subgroup's request for comment, the Subgroup received more than 100 comment letters. In February 2015, the Subgroup began meeting again via conference call twice weekly to review and discuss the comments. During its conference calls, the Subgroup discussed myriad issues, including how to deal with tiered networks, provider directory information and accuracy, "surprise bills" received by consumers for out-of-network services provided at participating facilities, essential community providers (ECPs) and limited scope dental and visions benefit plans. The Subgroup finished its review of the comments in August 2015 and released a second draft of proposed revisions to Model #74 with a Sept. 22, 2015, comment deadline. The Subgroup held three conference calls to discuss the comments received. The Subgroup adopted the proposed revisions to Model #74 Oct. 12, 2015, via conference call and submitted the draft to the Regulatory Framework (B) Task Force for its consideration. The Regulatory Framework (B) Task Force adopted the proposed revisions Oct. 22, 2015. The Health Insurance and Managed Care (B) Committee adopted the revisions Nov. 3, 2015.

The proposed revisions to Model #74 include a number of enhancements, including more specific requirements in Section 5—Network Adequacy concerning network sufficiency, how network sufficiency is to be determined and who is to determine network sufficiency. The revisions also add a new section concerning provider directories. This section describes what information must be included in both print and electronic directories to help consumers select a health benefit plan. It also includes a requirement for health carriers to periodically audit their provider directories for accuracy. The proposed revisions to Model #74 also include a new section, Section 7—Requirements for Participating Facility Providers with Out-of-Network Facility-Based Providers. This section addresses a narrow aspect of the so-called "surprise bill" issue (balanced billing) by establishing a mechanism for consumers to deal with bills they received for services provided by out-of-network facility-based providers while receiving treatment at an in-network facility. Section 7 also includes a provider mediation process for payment of out-of-network facility-based provider remittances for those providers who object to the amount of the payment they received for the out-of-network services they provided using the established payment rate. The proposed revisions to Model #74 also add a specific new section concerning provider directories. This new section establishes requirements for health carriers concerning the specific information that must be included in the directories for health care professionals, hospitals and other types of facilities to assist consumers in selecting a health benefit plan. It also includes requirements for carriers to help ensure the accuracy of the directories, including a periodic audit requirement.

2. Name of Group Responsible for Drafting the Model and States Participating

Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force drafted the proposed revisions to Model #74. The members of the Subgroup were: Wisconsin, Chair; California; Colorado; Missouri; Montana; Nebraska; Nevada; New Mexico; Oregon; Rhode Island; Tennessee; and Washington.

3. Project Authorized by What Charge and Date First Given to the Group

Based on the charge below, the Regulatory Framework (B) Task Force established the Network Adequacy Model Review (B) Subgroup in March 2014 to consider revisions to Model #74.

"Continue to review the model law review recommendations of NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group and, as appropriate, appoint a working group to revise the NAIC model(s) prioritized for revision in 2014.—*Important*"

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.; include any parties outside the members that participated)

Beginning in March 2014 and ending in October 2015, the Subgroup reviewed and discussed all of the comments received as part of the drafting process. More than 100 different interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, health care providers, hospitals, insurers and health care facilities. Each draft of proposed revisions was posted to the Subgroup's page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call twice weekly during the drafting process and also held in-person meetings at the NAIC national meetings.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning in March 2014 and ending in October 2015, the Subgroup reviewed and discussed all of the comments received. More than 100 different interested parties participated in the process. The interested parties represented all stakeholder groups, including consumers, health care providers, hospitals, insurers and health care facilities. Each draft of proposed revisions with public comment deadlines was posted to the Subgroup's page on the NAIC website. All comment letters received also were posted. The Subgroup met via conference call twice weekly during the drafting process and also held in-person meetings at the NAIC national meetings.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response)

A number of significant issues were raised and addressed. One of the issues was whether to, and if so, in what manner exempt limited scope dental and vision plans because the focus of Model #74 is on health benefit plans that provide major medical benefits. After several discussions, the Subgroup reviewed the draft and decided to exempt these types of limited benefit plans from specific provisions in Model #74 that would not make any sense to be applied to such plans.

Another major issue the Subgroup encountered was addressing the issue of "surprise bills." These are bills that consumers receive for services provided by non-participating providers in situations where the consumer may be in a participating facility, but while in the participating facility received services from a non-participating provider. The Subgroup decided to address one narrow aspect of the "surprise bill" issue in adding Section 7—Requirements for Participating Facilities with Non-Participating Facility-Based Providers. Section 7 sets out a process for payment of bills that consumers receive from non-participating facility-based providers for services provided at a participating facility.

The Subgroup also encountered a number of issues related to provider tiering. The Subgroup did not include specific provisions related to provider tiering, but included references to provider tiering throughout the draft, including a definition of "tiered network." The proposed revisions also include requirements in Section 9—Provider Directories for health carriers to include information in their directories identifying the tier within which each specific provider, hospital or other type of facility in the network is placed.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

Section-by-Section Summary of Proposed Revisions

Section 1. Short Title

The proposed revisions to Model #74 change the title to "Health Benefit Plan Network Access and Adequacy Act" in order to reflect network adequacy requirements apply to any health benefit plan that uses a network to provide covered benefits to covered persons, not just managed care plans.

Section 2. Purpose and Intent

The proposed revisions to Model #74 make clarifying revisions to this section. In addition, the revisions add language to this section specifically requiring health carriers to maintain and follow the access plans required under Section 5.

Section 3. Definitions

The proposed revisions to Model #74 add, revise and delete definitions to reflect the substantive changes made in the other sections of the Act. Among the new definitions are definitions of the terms "balance billing," "essential community provider," "limited scope dental plan," "limited scope vision plan," "network plan," and "telehealth or telemedicine." The proposed revisions to Model #74 delete definitions for the terms "closed plan," "health indemnity plan," "managed care plan" and "open plan."

Section 4. Applicability and Scope

The proposed revisions to Model #74 revise this section to have the model's provisions apply to all health carriers that offer network plans. In addition, the revisions include a carve out from having to comply with certain provisions of Model #74 for limited scope dental plans or limited scope vision plans because those provisions, which are focused on health benefit plans that offer comprehensive major medical benefits, are not suitable for the these types of limited benefit plans.

Section 5. Network Adequacy

The proposed revisions to Model #74 enhance the existing provisions of this section to more clearly state what will be considered a sufficient network and specifically require the domiciliary commissioner to determine network sufficiency in accordance with the requirements of this section. The proposed revisions include a requirement that health carriers have a process to ensure 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 make other arrangements acceptable to the domiciliary commissioner, when: 1) the carrier has a sufficient network but does not have the type of participating provider available to provide the covered benefit or it does not have a participating provider available without unreasonable travel or delay; or 2) the carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay. The proposed revisions also enhance the type of information that carriers much describe or include in their access plans submitted to the domiciliary commissioner. The proposed revisions give the domiciliary commissioner the option to require health carriers to submit the access plan for prior approval or for review.

Section 6. Requirements for Health Carriers and Participating Providers

The proposed revisions to Model #74 clarify the provisions in this section concerning the continuity of care both 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 proposed revisions also add provider tiering to the health carrier selection standards and add an option for insurance commissioners not only review the standards, but also approve the standards. In addition, the proposed revisions require that a description in plain language of the standards that a health carrier uses for selecting and tiering participating providers be made available to the public.

The proposed revisions to Model #74 also require that at the time a contract is signed, a health carrier and, if appropriate, its intermediary, shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract. While the contract is in force, the carrier also is required to timely notify a participating provider of any changes to those provisions or documents that could result in material changes in the contract. The proposed revisions also require the health carrier to timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider.

Section 7. Requirements for Participating Facilities with Non-Participating Facility-Based Providers

The proposed revisions to Model #74 add this section. This section sets out the requirements for addressing one narrow aspect of the so-called "surprise bill" issue in the situation where a covered person may receive for services provided at a participating facility by a non-participating facility-based provider. "Facility-based provider" is defined in this section as 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 facility or ambulatory facility setting. This section establishes limitations on balance billing for non-participating facility-based providers if the difference in the billed charge and the plan's allowable amount is more than $500. Health carriers are required to develop a program for payment of non-participating facility-based provider bills submitted to the carrier from the covered person. Under this program, the health carrier can elect to pay the non-participating facility-based provider bill as submitted or the health carrier may pay in accordance with the benchmark established in this section. The benchmark, which a state will set, for non-participating facility-based provider payments is presumed to be reasonable if it 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. In the drafting note for this section related to the benchmark, the proposed revisions discuss having a state use other default reimbursement methodologies, such as: a) 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.

The proposed revisions to Model #74 also include an enforcement provision recognizing that some of the provisions of this section will have to be enforced by other appropriate state agencies in addition to the state insurance department. Similar language also is included in the provision concerning the adoption of regulations.

Section 8. Disclosure and Notice Requirements

The proposed revisions to Model #74 add this section. This section requires health carriers to develop a written disclosure or notice to be provided to covered persons at the time of pre-certification that the facility that is in the covered person's network there is the possibility that the covered person could be treated by a health care professional that is not in the same network. This section also specifies what information is to be included in the disclosure or notice, including informing covered persons of the options available to access covered services from a participating provider.

This section also requires a facility, as part of its contract with a health carrier, to develop a written disclosure or notice to be provided to covered persons within 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, confirming that the facility is a participating provider of the covered person's network plan and informing covered persons that certain health care professionals who may provide services to the covered person at the facility may not be a participating provider in the same network.

Section 9. Provider Directories

The proposed revisions to Model #74 add this section. This section establishes requirements for health carriers related to electronic and print provider directories. This section describes what general and specific information must be included in both print and electronic directories to enable consumers select a health benefit plan most appropriate to their needs. It also includes a requirement for health carriers to update their provider directories at least monthly and to periodically audit them for accuracy.

Section 10. Intermediaries

The proposed revisions to Model #74 add one new provision to this section specifying that to the extent a health carrier delegates its responsibilities under this model to an intermediary, the health carrier retains full responsibility for the intermediary's compliance with the requirements of this model.

Section 11. Filing Requirements and State Administration

The proposed revisions to Model #74 make a few clarifying changes to this section concerning the timing of filing sample contract forms. The revisions also provide options for each state to decide whether to require health carriers to file the sample contract forms and any material changes with the domiciliary commissioner for informational purposes or prior approval.

Section 12. Contracting

The proposed revisions to Model #74 make no changes to this section.

Section 13. Enforcement

The proposed revisions to Model #74 make clarifying changes to this section to require that if the domiciliary commissioner determines that a health carrier has not contracted with a sufficient number of participating providers, or that a health carrier's network access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with Model #74, or that a health carrier has not complied with a provision of this model, the domiciliary commissioner shall require the health carrier to modify its access plan or institute a corrective action plan, as appropriate, or the domiciliary commissioner may use any of the commissioner's other enforcement powers to obtain compliance with this model.

Section 14. Regulations

The proposed revisions to Model #74 make no changes to this section.

Section 15. Penalties

The proposed revisions to Model #74 make no changes to this section.

Section 16. Separability

The proposed revisions to Model #74 make no changes to this section.

Section 17. Effective Date

The proposed revisions to Model #74 add a transition period for compliance with the amended provisions of Section 5 of this model.