

# ENSURING CONSUMERS' ACCESS TO CARE:

Network Adequacy State Insurance Survey  
Findings and Recommendations for Regulatory  
Reforms in a Changing Insurance Market

November 2014 | Health Management Associates

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*This project was generously supported through a grant from the Robert Wood Johnson Foundation.*

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The Affordable Care Act (ACA) includes many reforms intended to make health care more affordable and accessible to consumers. Of note here, the ACA standardizes the list of covered benefits, sets a floor for the amount of financial coverage, and establishes a maximum limit for enrollees' annual out-of-pocket expenses. These reforms help consumers compare health plans and use their coverage, but they accelerated a trend towards tighter provider networks and tiered networks, as insurers turn to new levers to keep premium costs low. As a result, the issue of network adequacy is elevated. Health insurance coverage is meaningless if consumers cannot get the covered benefits promised to them due to network constraints.

To ensure that patients and consumers have access to the care they need in a changing health care environment, the Consumer Representatives to the National Association of Insurance Commissioners (NAIC) have for several years urged the NAIC to update its Managed Care Network Adequacy Model Act. We are pleased that the NAIC, through its Network Adequacy Model Review Subgroup, is now undertaking this important task. To help inform the NAIC's work, as well as the work of state and federal regulators, the consumer representatives offer this report, **"Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market."** To develop this report, the Consumer Representatives to the NAIC commissioned Health Management Associates to evaluate the current status of state requirements related to network adequacy, the challenges regulators face, and best practices for ensuring network access. We then make recommendations for revising the Network Adequacy Model Act. We hope these findings and recommendations will be helpful to regulators moving forward.

## Acknowledgments

The Consumer Representatives to the NAIC would like to extend our deep and sincere appreciation to Dianne Longley, a respected former regulator at the Texas Department of Insurance, for her thorough and dedicated work in researching and writing this report. She currently works at Health Management Associates in the area of health policy. We would also like to thank Samia Abbass at Health Access California and Ashley Williams and Sarah Dash at Georgetown University's Center on Health Insurance Reforms for their tremendous support on this project. We also thank Stefanay Allen and DragoonStudios in Atlanta for their creative design for this paper. We would also like to express our heartfelt gratitude to the Robert Wood Johnson Foundation for their generous support for this project. And finally, as always, we are grateful to the NAIC for giving us the ongoing opportunity to provide consumer-focused input to insurance regulators on health policy issues, including implementation of the ACA.



## Executive Summary



State and federal insurance regulators face new and complex challenges to ensuring that consumers' interests are monitored and protected in a rapidly evolving health insurance market. As consumers enter the insurance market in record numbers as a result of the Affordable Care Act (ACA), the increased competition and demand for health care services have created both new opportunities and new pressures for health plans and health care providers. Many insurers have responded by offering health plans with lower premiums in exchange for more limited access to health care providers. Although some reasonable trade-offs are necessary to ensure health coverage is affordable, the increasing use of "narrow networks" and tiered networks has focused additional attention on the regulation of health plan provider networks and the potential financial implications for consumers who receive out-of-network services.<sup>1</sup>

Historically, state oversight of network adequacy has varied significantly from state to state and, in many cases, has not kept up with changes in health plan designs. Recently, NAIC (National Association of Insurance Commissioners) president-elect Monica Lindeen noted in her testimony before the House of Representatives' Energy and Commerce Subcommittee on Health that older insurance statutes cannot fully accommodate the new health plan designs offered today, and that current state standards may need revisions to address network adequacy concerns. Commissioner Lindeen announced that in response to the changing market and concerns regarding regulatory standards, the NAIC has agreed to update its 1996 network adequacy model law, which is intended to establish requirements for health plans to assure adequacy, accessibility, transparency, and quality of health care services for consumers.<sup>2</sup>

In March of 2014, the NAIC Regulatory Framework (B) Task Force created the Network Adequacy Model Review Subgroup to develop recommendations for updating the Managed Care Plan Network Adequacy Model Act. Since May, the NAIC Subgroup has been holding weekly public conference calls and using the NAIC's open process to engage consumers, health care providers, business groups, insurers and other stakeholders in the review process. In response to the Subgroup's invitation to stakeholders to propose solutions, the NAIC Consumer Representatives offered to conduct a survey of all state Departments of Insurance (DOIs) to obtain information on statutory and regulatory requirements related to oversight of network adequacy, and to identify strategies used to monitor compliance with network adequacy requirements. Our goal through this effort was to identify challenges faced by regulators as well as "best practices" and successful initiatives used by states in order to develop recommendations for the NAIC's consideration. The survey was sent to DOIs in all 50 states and to regulators in Puerto Rico and the District of Columbia. The NAIC supported our efforts by encouraging states to respond to the survey and by allowing the Consumer Representatives to provide an overview of the survey project at the 2014 summer meeting. By September, DOIs had submitted a total of 38 completed surveys. The respondents represent states of varying sizes with different demographics, geographies, and health insurance exchange dynamics, providing excellent information on the current spectrum of regulatory approaches to network adequacy oversight and ensuring availability and transparency of information to enable consumers to make informed health plan purchasing decisions.

## Survey Results

Not surprisingly, the survey results confirm that States do not take a “one size fits all” approach to network adequacy oversight. As the highlights in the table below indicate, different marketplace dynamics, varying levels of statutory authority, and other state-specific factors impact the tools regulators have available and the degree to which health plans must comply with specific requirements. Complete survey results are included later in this report.

### SURVEY HIGHLIGHTS

- Most states have not adopted the NAIC Managed Care Plan Network Adequacy Model Act.
- The primary tool regulators use to monitor network adequacy is complaint data. Almost all states track network adequacy-related complaints but vary in the level of detail they collect.
- DOIs consistently report that one of the biggest challenges they face as regulators is developing consumer-friendly information and resources for consumers to help them understand the risks and potential costs associated with out-of-network services. While they agree consumers need better information to make informed decisions, they struggle to provide information in a clear, easy-to-understand format that addresses the variations in requirements for different types of health plans.
- Just over a third of states have requirements that Preferred Provider Organizations (PPOs) update their provider directories on a regular basis, such as annually or semi-annually.
- Overall, respondents indicate more regulatory authority exists for health maintenance organizations (HMOs) than PPO plans and even less regulatory oversight is in place for newer managed care products, such as Exclusive Provider Organizations (EPOs).
- Less than half of states have provisions in place to prohibit or limit a situation in which a member receives services from an out-of-network provider (such as an anesthesiologist) when treated at an in-network hospital. However, those requirements are limited in many cases to specific situations such as emergency services, and the level of protection varies widely based on the type of plan (HMO or PPO).
- Enforcement actions are rarely taken based on violations related to network adequacy. Only four states reported they usually take enforcement actions against more than one health plan a year due to network adequacy violations.

## Recommended Changes to Managed Care Plan Network Adequacy Model Act

In addition to providing a broad overview of the variety of regulatory approaches currently in place related to network adequacy, the survey results also identify opportunities for improved regulations that more accurately reflect the complexities of today’s health insurance market. While network adequacy oversight has evolved significantly in a few states, others have made little progress. To encourage states to consider opportunities for regulatory improvements, we have included in this report several recommendations for new state network adequacy oversight requirements and modifications to the NAIC Model Law based in part on responses and comments provided by survey respondents. Although these suggestions do not represent the only options for improving network adequacy, we hope the NAIC and state regulators will seriously consider integrating these ideas into the new Model Law requirements and in any legislative or regulatory changes states are considering.

- Expand the scope of existing network adequacy regulations to include all types of network plans, including HMOs, PPOs, Exclusive Provider Organizations (EPOs), and Point of Service (POS) plans, and plans with multi-tier provider networks.<sup>3</sup>
- DOIs should evaluate the methods used to educate consumers on the ability to file complaints with the Department and identify ways to improve outreach to consumers to ensure they are fully informed of the Department’s complaint process. Because regulators rely heavily on complaints as an indicator of potential problems with a health plan’s network, it is imperative that consumers are aware of the ability to file complaints with the DOI and the process for doing so. DOIs should also provide an on-line mail box for consumers to communicate problems or suggestions to the Department, even if the individual does not want to file an official complaint.

- Establish a process for regularly updating the NAIC Model Law to address oversight of new models of care, such as Accountable Care Organizations (ACOs) and other models that may evolve over time.
- Establish quantitative standards for meaningful, reasonable access to care, such as minimum provider-to-enrollee ratios, reasonable wait times for appointments based on urgency of the condition, and distance standards that require access to network providers within a reasonable distance from the enrollee's residence. While we recognize that geography and local market conditions make it challenging to set national quantitative standards that would be appropriate in every state, we believe it is important that states set such standards.
- Require health plans to submit and receive approval from DOI of access plans to ensure consumers are adequately protected from network deficiencies.
- Ensure consumers are provided sufficient information to identify and select between broad, narrow or ultra-narrow networks. In areas without sufficient choice, require health plans to offer at least one plan with a broad network or an out-of-network benefit, with limited exceptions to be determined by the Commissioner.
- Require all health plans, not just Qualified Health Plans (QHPs), to include access to Essential Community Providers.
- Require all network plans to include provisions that protect consumers from balance billing in all emergency situations and when receiving services from non-network facility-based providers in an in-network facility.
- Require providers to notify health plans and patients when leaving a network for any reason.
- Require health plan provider directories to be updated regularly, publicly available for both enrolled members and individuals shopping for coverage, and include standards for information that must be included to provide consumers with information on network differences and the potential financial impact on consumers depending on which plan they choose.
- Establish requirements guaranteeing continuity of care for individuals who are in the midst of an episode of care and their provider is dropped from or leaves the network or is moved to a higher cost tier.
- Create special enrollment periods to allow individuals to move to a new health plan when they rely on erroneous information published in a health plan's provider directory, their primary care provider becomes a non-participating provider, or a covered person is in the midst of a course of treatment and loses access to their specialty care provider or facility.
- Work with other state agencies to address balance billing concerns resulting from consumers needing to use out-of-network providers.
- Adopt standardized health plan reporting requirements to monitor frequency of out-of-network services and network adequacy, and identify circumstances where additional consumer protections or changes in regulatory processes are warranted. Require health plans to make information publicly available in a prominent position on their website. DOIs should also provide notice to consumers of the availability of such information and how it may be accessed.
- Establish a comprehensive, standardized list of complaint codes that all DOIs use to track consumer complaints related to network adequacy and access to care.
- Expand efforts to educate consumers on DOI complaint processes to ensure they are aware of their right to file a complaint and reduce any administrative barriers that may discourage consumers from filing complaints.
- States should not rely solely on health plan accreditation as a substitute for demonstrating network adequacy compliance, but should supplement accreditation with additional standards.



## Network Adequacy and Financial Implications for Consumers



Network adequacy refers to a health plan's ability to meet the medical needs of its enrollees by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all other health care services for which benefits are included under the terms of the insurance contract.<sup>4</sup> In the event an enrollee is unable to obtain covered services from an in-network health care provider and is treated by an out-of-network provider, the health plan may pay a much lower portion of the medical bill – or nothing at all – and the consumer may be faced with significantly higher cost-sharing that does not count toward their out-of-pocket limit. Depending on the circumstances, the provider may also then “balance bill” the patient for the remaining costs, which can be a significant amount of money depending on the services received and the payment provided by the insurer. While network adequacy is typically the primary focus of regulatory oversight, balance billing is directly linked to network access and creates additional challenges for regulators.

Although many states have struggled to determine how to best regulate provider networks in a way that ensures access to care while still allowing health plans flexibility in network design and network size in exchange for lower premiums, no single approach has evolved. Primary oversight of network adequacy for commercial benefit plans is delegated to state Departments of Insurance (DOIs) that have adopted varying approaches based, in part, on differences in statutory authority granted by their Legislature. In addition, the federal Department of Health and Human Services (HHS) also plays a role in network adequacy regulation in its oversight of requirements for Qualified Health Plans (QHPs) offered on state and federal health insurance exchanges.<sup>5</sup> While HHS has delegated network adequacy reviews to states in most cases, the requirements for QHP provider networks vary from those required of most commercial insurance plans, creating an additional complication for states in some cases. States that have created a separate entity to operate their exchange may also have a role in monitoring network adequacy of QHPs sold on the exchange.

The initial network adequacy regulatory requirements developed by states and the NAIC were designed for HMOs but have evolved over time to include other types of network plans including PPOs and, to a much lesser extent, EPOs.<sup>6</sup> In most if not all states, network adequacy regulations are more comprehensive for HMO plans than for PPOs due to the more restrictive HMO requirements that limit consumers' ability to use any provider other than those included in the HMO network except in emergency situations or in cases where an enrollee does not have access to covered services from a network provider. Generally, in an HMO health plan, the HMO must provide all covered services through a network provider, or arrange for an out-of-network provider to care for the enrollee at no additional cost if an in-network provider is not available. As long as the enrollee uses an in-network provider or receives approval for out-of-network services, the enrollee should not be balance billed for fees other than their standard co-payment.

However, network adequacy standards for PPOs are usually more complicated for regulators and consumers since PPOs do not provide prepaid care and benefits are included to allow enrollees to choose an out-of-network provider. Out-of-pocket costs for services are lower as long as the individual uses an in-network provider but may be significantly higher when receiving services from an out-of-network provider. While some state laws require PPOs to meet certain network adequacy standards, the criteria are frequently much less stringent than those for HMOs. As with HMOs, PPO enrollees are protected

from unexpected bills as long as they stay in their network or use out-of-network providers only when an in-network provider is unavailable and the PPO authorizes the use of a non-network provider. However, unlike HMOs, in the event a PPO enrollee is treated by an out-of-network provider, even when due to no choice of their own, the enrollee is responsible for the generally higher cost-sharing amounts and any remaining balance billed by the provider after the health plan has paid its portion of the bill.

## **Impact on Consumers of Inadequate Network Adequacy Regulatory Oversight**

When a network plan enrollee does receive out-of-network services, the costs can be significant, even in cases where the enrollee had no control over the circumstances and did not knowingly choose to use an out-of-network provider. To better understand the need for improved consumer protections, a brief discussion of the circumstances created by inadequate networks helps to illustrate the frustrations of consumers who often have no control over the providers they see, even when “playing by the health plan rules” and making every effort to use only network providers. Following is a brief overview of situations in which consumers may receive treatment from out-of-network providers.

### **• Treatment by an Out-of-Network Provider During a Pre-Approved In-Network Hospital Admission**

Consumers planning a hospital stay select an in-network hospital and an in-network provider for their primary services (such as surgery), but they must use the ancillary providers (e.g., anesthesiologists, radiologists, pathologists) with which the hospital contracts for other services received, such as lab work, anesthesiology, or imaging services. If those facility-based providers do not also contract with the patient’s health plan, the patient is frequently billed for out-of-network charges their health insurer does not pay. Depending on the services, the out-of-network bill can amount to thousands of dollars that the patient did not anticipate or have any control over, despite their adherence to the health plan requirement that they use an in-network facility.<sup>7</sup> In many cases, consumers are not even aware they were treated by a non-network provider until they receive a “surprise” bill.

### **• Balance Billing in an Emergency**

Under section 2719A of the Public Health Service Act, all non-grandfathered health plans are required to charge in-network cost-sharing for emergency services provided by an out-of-network emergency department (ED) physician or for emergency services provided by an out-of-network hospital. However, despite this consumer protection, consumers can still find themselves subject to high out-of-pocket costs. When a consumer visits an emergency room and is treated by an emergency room doctor who does not participate in their insurance network, they can still be balance billed by the doctor and the hospital. Because hospital-based physicians often decide which insurance plans to participate in, a visit to the emergency room can result in multiple separate bills from different providers. An Avalere Health study commissioned by the American Heart Association found that hospital-based diagnostic radiologists were less likely to be included in QHP networks, compared to cardiologists and neurologists. When hospital-based physicians do not contract with the same plans as the hospital, consumers end up receiving out-of-network services even if the hospital is an in-network facility. Depending on the level of the emergency, even an informed consumer may be unable to determine whether the contracted ED providers are in their network since provider directories do not typically list hospital-level participating providers. For emergency services, the patient’s balance bill can be especially significant as the amount an insurance company pays a doctor (the contract amount) is often much lower than the provider’s actual billed charge.<sup>8</sup> In addition, if a patient who is treated and stabilized at an out-of-network hospital ED needs to be admitted as an inpatient, they can then face the difficult choice of staying and being subject to out-of-network cost-sharing (which could be 100 percent, depending on the type of plan they have) and balance billing or being transferred to an in-network hospital, which may not be in their best medical interest.

### **• No Access to a Particular Type of Provider (e.g., Pediatric Orthopedist, Neonatologist)**

Regional shortages of certain specialty providers limit access to specialty care and can inhibit the health plan’s ability to develop adequate networks. Shortages occur in both rural and heavily populated urban areas and are most commonly seen for certain specialty services that may only be provided at a select group of facilities. While health plans are required to ensure access to necessary care within reasonable time frames, consumers may find themselves battling with health plans to obtain authorizations for out-of-network services when specialty providers are not included in the health plan’s network. Members unwilling to wait for approval may seek care from an out-of-network provider that could result in balance billing if the health plan does not cover the full cost. Even when approval is issued, the health

plan's payment arrangement may still leave consumers with higher costs. Enrollees with uncommon health conditions are particularly vulnerable to these circumstances if the network does not provide access to highly specialized services available from only a limited number of providers.

#### • **Unreasonable Delays in Access to Care Due to an Insufficient Network**

Consumers may also encounter delays in receiving services when a provider network is insufficient to meet the volume of services required by the enrollees they serve. Similar to the illustration above, consumers may choose to go to an out-of-network provider because they cannot find an in-network provider accepting new patients or because they do not believe they can wait for an available appointment from an in-network provider. If so, they will be responsible for costs not covered by the health plan.

#### • **No Access to a Particular Treatment Due to Lack of Providers Who Offer It**

Consumers with chronic or serious medical conditions can be particularly impacted if a provider network does not include providers who can treat their particular condition. This is especially true for specialty providers at academic institutions or centers of excellence who offer services that are not available at another facility. An Avalere Health study commissioned by the American Heart Association found that inclusion of Comprehensive Stroke Centers (CSC) and specialty physicians affiliated with those facilities varied widely across 10 regions; however, the study found that 23 percent of the QHPs reviewed did not include a single CSC in their network and inclusion of select specialty physicians ranged from a low of 8 percent in Los Angeles to a high of 83 percent in Philadelphia. If the provider is not included in the enrollee's network, the enrollee may seek an authorization for services from the health plan, but may still be responsible for out-of-network costs or subject to balance billing. If they are unable to receive an authorization but decide to seek services anyway, the costs can be even higher.

Although consumers may be faced with these challenges in any network plan, individuals enrolled in “narrow networks” may bear an increased risk of encountering difficulties obtaining in-network services. In an effort to attract new consumers entering the health insurance market through the exchanges, both HMO and PPO health plans have increasingly turned to more limited “narrow networks” that offer fewer provider choices in exchange for lower premiums.<sup>9</sup> As this trend continues to grow more popular among health plans, consumers' access to and choice of providers may be severely limited, which may also lead to increased consumer complaints about lack of choice among providers or inability to access certain specialty providers in a timely manner. For consumers with limited financial resources who have chosen a narrow network plan due in part to the lower premium, the cost of unforeseen balance bills can create financial risks that are especially difficult for them to absorb. In some states, severely limited networks have left large numbers of doctors and hospitals completely out of the provider network, frustrating consumers who need, or would like, to receive care from the excluded providers. For example:

- California consumers recently filed lawsuits against insurance companies alleging they offered inadequate networks of doctors and hospitals and provided incorrect information about participating providers, often leaving consumers with large medical bills.<sup>10</sup> Consumers claim they did not find out the providers were out-of-network until after they received care and were forced to pay out-of-network charges. Claimants also report they were unable to switch health plans despite the fact that they selected the plan based on inaccurate provider information.
- In Washington, four of the seven health insurers selling plans in the health insurance exchange excluded several of the most prestigious Seattle hospitals, including Seattle Children's Hospital.<sup>11</sup> One plan included only one hospital in its network of hospital providers, and the hospital does not offer child delivery services. In response to complaints from providers and consumers that such networks do not provide reasonable access to necessary medical care, the Insurance Commissioner adopted more stringent network adequacy requirements for 2015 that require plans to ensure provider directories are accurate and clearly identify which providers participate in which network. Health plans must also include enough providers to meet time and/or distance requirements to ensure enrollees have a sufficient number of network providers to meet enrollees' needs in a reasonable time frame.
- In New Hampshire, the sole insurer participating in the health insurance exchange, Anthem, reduced the breadth of its provider network by excluding over 30 percent of the state's hospitals.<sup>12</sup> In response to complaints from consumer and provider groups, as well as federal and state policymakers, the New Hampshire Department of Insurance initiated a review of its network adequacy standards and has drafted new rules which, if adopted, will apply to plans offered in the plan year beginning January 2016. For 2015, four new insurers are entering the market, and all hospitals in the state will be included in at least one plan network.<sup>13</sup>

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As network adequacy has received increased attention, regulators have begun to focus on improving the current regulatory framework for oversight of health plan networks and payment policies related to out-of-network bills. In doing so, some regulators have relied primarily on anecdotal data captured through complaints filed by consumers, which only identifies problems after-the-fact and relies on consumers' awareness of the complaint process. Because not all consumers affected by inadequate networks or balance billing actually file complaints with DOIs, the full extent of the problem is unknown. While most states have little data to confirm the extent to which health plan enrollees receive out-of-network services, and even less information on the frequency of balance billing, a few states have increased efforts to collect data to assist in their oversight activities and to inform the development of new regulatory options. For example:

- A Texas Department of Insurance (TDI) regulation that took effect in 2013 requires Texas PPOs to provide to TDI out-of-network service data for hospital-based physician types, including emergency department (ED) doctors. Analysis of the data published by the Center for Public Policy Priorities shows that Texas consumers are at significant risk of being balance billed for services provided by non-network providers, even when using in-network hospitals. For example, two of the largest insurers in the state reported that 48 percent and 56 percent of their in-network hospitals had no in-network ED doctors. Out-of-network fees paid to ED physicians were more than twice as high as fees paid to other out-of-network hospital-based providers. One plan in particular reported significantly higher levels of hospitals with no in-network facility-based providers, including 56 percent of hospitals with no in-network ED physicians, 38 percent of hospitals with no in-network anesthesiologists, and 31 percent of hospitals with no in-network radiologists.<sup>14</sup>
- A review of consumer complaints related to health insurance reimbursements in New York revealed that more than 10,000 complaints related to balance billing were filed since 2008. In describing new legislation that will provide additional data on out-of-network services and authorizes regulations to improve network adequacy oversight, Benjamin Lawsky, Superintendent of Financial Services and the chief insurance regulator for the state of New York, noted, "The heart of the bill came out of the fact that the No. 1 complaint on health insurance issues we receive year after year is people who get stuck with surprise balance bills."<sup>15</sup>

While these examples of data collection by DOIs are a good beginning, they are still uncommon and represent the exception rather than the rule. We hope these and other activities states are pursuing will encourage the NAIC and other state DOIs to consider taking similar steps to improve protections for the consumers enrolled in network plans.



## Current Federal Regulatory Structure



While states have historically been the primary regulators of health insurance, with the implementation of the ACA, health plans may be subject to oversight by not only the state DOI, but also the state Medicaid agency and the entity operating the health insurance exchange, which in some cases is the Centers for Medicare and Medicaid Services (CMS).<sup>16</sup> Since the adoption of the ACA and subsequent debate regarding the division of state and federal regulatory responsibilities, a number of states have consistently expressed concern regarding expansion of federal oversight of state insurance markets. In an April 2014 letter from officers of the NAIC to the Center for Consumer Information and Insurance Oversight, regulators state, “We believe federal regulation of network adequacy standards will lead to conflicting standards between state and federal requirements and that network adequacy regulation will be most effective at the state level where the needs of consumers, the cost of care, and the standards of the area, can best be evaluated.”<sup>17</sup>

Despite the resistance from states, federal regulators have increasingly indicated a willingness to regulate network adequacy and access to care. For example, as will be discussed in greater detail later in this report, CMS has signaled plans for greater network adequacy oversight and regulation of qualified health plans (QHPs) certified for inclusion in federally facilitated exchanges. Similarly, the Departments of Health and Human Services, Labor, and Treasury recently issued a number of Frequently Asked Question guidance documents clarifying how a non-grandfathered health plan that “utilizes reference-based pricing (or similar network design)” will be evaluated to ensure that “it provides adequate access to quality providers”.<sup>18</sup> This FAQ applies to all non-grandfathered health plans using reference-based pricing or a similar scheme. Its reasoning would apply to any restrictive network design.

To better understand the impact of the federal requirements and how state regulations can be effectively designed to meet both federal and state oversight requirements, the following section provides an overview of the federal statutory and regulatory requirements applicable to the networks of QHPs offered to exchange enrollees. The information includes comments provided in proposed and adopted regulations to provide the perspective of federal regulators and their expectations with regard to network adequacy oversight.

### ACA Requirements Related to Network Adequacy

Section 1311(c) of the ACA requires the Secretary of Health and Human Services to adopt regulations establishing criteria for the certification of QHPs, including the following network adequacy requirements:

- Ensure a “sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c)<sup>19</sup> of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers”, and
- Include within plan networks “essential community providers, where available, that serve predominantly low income, medically underserved individuals, such as health providers defined in Section 340B of the Public Health Service Act.”

The ACA describes providers who are considered to be essential community providers through its reference to Section 340B of the Public Health Service Act (PHSA), which guarantees access to discounted drugs for certain healthcare providers that serve low income populations. In addition, ACA Section 1311 also requires the Secretary to establish criteria for all QHPs to obtain accreditation by a recognized entity on the basis of local performance in several categories, including consumer access and network adequacy.

Also of note, Section 2707(b) limits consumers' annual out-of-pocket costs (i.e., cost-sharing) paid for covered health plan services, but Section 1302(c) of the ACA does not require insurers to count costs paid by consumers to out-of-network providers towards their annual out-of-pocket limit. The Department of Health and Human Services subsequently adopted federal rules consistent with this restriction. As noted above, a recent tri-agency Frequently Asked Questions guidance suggests that network designs (including some reference-based pricing programs) may be a subterfuge for evading the out-of-pocket limit, however, and thus be illegal.<sup>20</sup>

## **U.S. Health and Human Services Regulations Related to Network Adequacy**

On March 12, 2012, HHS issued a final rule to implement the provisions related to establishment of health insurance exchanges under the ACA.<sup>21</sup> The rule finalized two separate proposed rules issued in 2011:

- Establishment of Exchanges and Qualified Health Plans (July 15, 2011); and
- Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers (August 17, 2011).

In the preamble, HHS states that while it recognizes that national standards are appropriate in some circumstances, states are “best equipped to adapt the minimum Exchange functions to their local markets and the unique needs of their residents.” The intent is to provide states “substantial discretion” in the design and operation of an exchange.

## **HHS Regulatory Impact Analysis of Final Exchange Rule**

In the regulatory impact analysis of the final rule, HHS included explanations regarding its rationale for network adequacy requirements.<sup>22</sup> HHS restates that the rule permits state discretion in setting network adequacy standards. An exchange may determine that existing state requirements for commercial providers is sufficient for QHPs, provided that QHPs will be required to maintain a network that is sufficient in number and types of providers so that services will be provided without unreasonable delay. If states use that approach, HHS reports that this regulatory provision will have no cost impact on premiums. HHS also says that, “While it is not expected, the Exchange could set additional standards in accordance with current provider market characteristics and consumer needs, which could have a minimal cost impact.”

If a state exchange sets QHP network adequacy standards that go beyond what is currently required in the market, HHS acknowledges that health plans may need to contract with additional providers at higher rates. If that is the case, premium rates are also likely to be higher. HHS says that the network adequacy standards are designed to maintain a “basic level of consumer protection,” while allowing QHP issuers to compete for business based on their networks, quality of coverage, and premiums.

HHS also notes that the final rule “permits QHP issuers to contract with a sufficient number and geographic distribution of essential community providers to provide timely access to services for low-income and medically underserved individuals. QHP issuers are not required to contract with all essential community providers and, except for certain limited categories of providers, the issuer is not required to contract with an essential community provider if the provider does not accept the issuer's generally accepted rates for participating providers.”

## Final Rule Requirements Related to Network Adequacy

Network adequacy and related requirements are included in both Section 155 related to responsibilities of the exchange and Section 156 related to requirements for issuers of QHPs. Following is a summary of those provisions as stated in the final rule.

### Establishment of Exchange Network Adequacy Standards (45 CFR §155.1050)

This section of the rule requires the exchange to ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees to meet the standards for network adequacy specified in §156.230.

#### Final Rule Provisions:

- The exchange must ensure that the provider network of each QHP meets the standards described in §156.230 (i.e., includes a sufficient number and type of providers, includes essential community providers, requires plans to provide provider directories, and allows plans to limit enrollment if they do not have the capacity to serve additional enrollees);
- The U.S. Office of Personnel Management will oversee network adequacy standards and compliance for multi-State plans;
- The exchange cannot prohibit a QHP issuer from contracting with any essential community provider as designated in §156.235(c).

### Network Adequacy Standards (45 CFR §156.230)

This section provides network adequacy standards required of QHPs. In the preamble response to comments, HHS notes there are several competing goals in establishing requirements for adequate networks. In balancing the varying perspectives, HHS modified the language in the proposed rule to more closely align with the NAIC Managed Care Plan Network Adequacy Model Act. HHS notes that the revised language better conveys their expectations concerning the number and variety of providers that are required in a QHP's network. The revisions also establish a baseline – “All services... without reasonable delay” – for determining whether a network meets the required standard. HHS states that the revised language provides states with the discretion needed to ensure network adequacy standards within the exchange are consistent with standards applied outside the exchange, and reflect local conditions. The rule also says that “...placing the responsibility for compliance on QHP issuers rather than directing the Exchange to develop standards, is more consistent with current State practice.”

In response to recommendations that the rule prohibit a network from being deemed inadequate in a professional shortage area, HHS repeats that states should have flexibility to develop local solutions to ensure access. Further, HHS believes that the standards for inclusion of essential community providers in networks will help strengthen access in medically-underserved areas.

In response to comments suggesting that the rule require the inclusion of specific provider types and that networks meet a “uniform growth standard” to ensure they are able to accept new enrollees, HHS states that the final rule is modified to require that networks include sufficient numbers and types of providers, including providers specializing in mental health and substance abuse services, to ensure appropriate access to care. HHS also reiterates comments made in the proposed rule preamble, urging states to consider local demographics and availability of providers when developing network adequacy standards.

Several commenters suggested the rules impose more stringent standards for network directories. The final rule notes that exchanges will be given discretion regarding the information included in the directory and frequency of required updates, but HHS expects directories to include information on each provider's licensure or credentials, specialty and contact information, and to consider the information needs of both current and potential enrollees. The rule requires that provider directories comply with the requirements in §155.230, which includes accommodations for individuals with limited English proficiency and/or disabilities.<sup>23</sup>

HHS also declined to establish a uniform standard for patient notifications when a provider leaves a network. The rule states that such a requirement may not be consistent with the non-exchange market, and might raise QHP administrative costs. Finally, the preamble addresses comments suggesting that QHPs are obligated to include health programs operated by or on behalf of Indian tribes based on section 408 of the Indian Health Care Improvement Act (IHCA). HHS responds that the intent of section 408 is to confirm that Indian providers are eligible to receive payment from Federal Health Care Programs if certain standards are met. Section 26 of IHCA provides that Indian providers are entitled to third party payments, including

QHPs, up to the reasonable charges or the highest amount an insurer would pay to other providers eligible for payment. HHS declined to require QHPs to include Indian providers/programs but points out that Section 26 of IHCAA will foster network participation because it benefits QHPs to contract with Indian providers in order to establish the provider payment terms.

#### **Final Rule Provisions:**

- QHP networks must include essential community providers as described in §156.235 (see discussion below);
- QHP networks must include a sufficient number and types of providers, including mental health and substance abuse specialists, to ensure all services are available without unreasonable delay;
- QHP networks must meet the provisions of Section 2702(c) of the PHS Act (which allows QHPs to limit their enrollment to individuals who live, work, or reside within their service areas, and to close enrollment if they do not have the capacity to serve additional members.);
- QHPs must make its provider directory available to the exchange for online publication, and provide hard copies to potential enrollees upon request. The directory must identify providers that are not accepting new patients.

#### **Essential Community Providers (45 CFR §156.235)**

This section of the rule requires a QHP issuer to include within its network a sufficient number of essential community providers (ECPs) who serve predominantly low-income, medically underserved individuals. The proposed rule uses a definition of ECPs that is consistent with the ACA, which includes all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act.

Section 340B(a)(4) refers to the Drug Discount Program that serves vulnerable patient populations and identifies covered entities.<sup>24</sup> Section 1927 of the PHS Act allows the Secretary of HHS to identify any “safety net facility or entity” that would benefit from nominal drug pricing under the Medicaid program.<sup>25</sup>

#### **Final Rule Provisions:**

- QHP issuers must have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of providers for low-income, medically underserved individuals;
- QHP issuers that employ their own physicians or contract with a single medical group to serve enrollees are required to have a sufficient number and geographic distribution of either employed or contracted providers and hospitals to ensure reasonable and timely access to care for low-income, medically underserved enrollees;
- Essential Community Providers are defined as those serving predominantly low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the PHS Act;
- No QHP issuer is required to contract with an ECP if the provider refuses to accept the generally applicable payment rates of the issuer;
- FQHCs are entitled to payments at least equal to what would have been paid under the applicable Medicaid Prospective Payment System (PPS) rate, or may accept a mutually agreed upon rate, as long as the payment rate is at least equal to the payment rate other providers would receive for the same service.

#### **Accreditation Requirements (45 CFR §156.275) and Accreditation Timeline (45 CFR §155.1045)**

The ACA requires accreditation of all QHPs as a way to ensure plans meet a minimum level of quality of care and patient satisfaction. This requirement is important to the discussion of network adequacy requirements because accreditation organizations include access to care or network adequacy standards as one criteria for certification.

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**Final Rule Provisions:**

- QHP Issuers must be accredited in the following categories:
  - o Clinical quality measures;
  - o Patient experience rating on a standard CAHPS survey;
  - o Consumer access;
  - o Utilization management;
  - o Quality assurance;
  - o Provider credentialing;
  - o Complaints and appeals;
  - o Network adequacy and access; and
  - o Patient information programs.
- QHPs must authorize the accrediting entity to release to the exchange and HHS a copy of its most recent accreditation survey, along with any additional survey-related information HHS may require.
- QHPs must be accredited within the timeframe established by the exchange, and maintain accreditation as a condition of being certified as a QHP.

The exchange will establish a time frame in which a QHP must be accredited. The OPM determines the accreditation time period for multi-state plans.



## State vs. Federal Regulatory Authority over Network Adequacy



With the passage of the ACA and the dual regulatory oversight of network adequacy requirements, state and federal regulators have at least initially addressed some issues related to coordination of network adequacy oversight. The majority of states are enforcing ACA health insurance market reforms and have worked with federal regulators to develop processes and procedures that more clearly define and coordinate state and federal roles. However, some states have determined they lack either the authority, the ability, or, in some cases, both to enforce ACA market reform provisions. CMS agreed to enter into collaborative agreements with any state willing and able to perform regulatory functions for federal regulations, allowing the state to use the same regulatory framework used to ensure compliance with state law. However, in 2013, six states – Arizona (for the group PPO market only), Alabama, Missouri, Oklahoma, Texas, and Wyoming – determined they did not have the authority to enforce ACA provisions. Those states have worked with CCIIO and health plans to implement processes to delegate certain oversight functions to the appropriate federal agency. Arizona subsequently notified CMS the state would assume full enforcement responsibilities as of January 1, 2014.<sup>26</sup>

As it did in 2013, in March 2014, CMS released a letter to issuers (*Final 2015 Letter to Issuers in the Federally-facilitated Marketplaces*<sup>27</sup>) to clarify the federal regulatory approach and requirements for issuers applying for QHP certification and provide additional regulatory guidance to issuers selling products in FFMs beginning in January 2015. States performing plan management functions in an FFM have more flexibility in evaluating compliance with some certification standards and, in some cases, are allowed to adjust processes.

In the March 2014 letter, CMS articulated a different approach it would take to assuring network adequacy standards were met in FFMs for QHPs undergoing approval in 2014 for sale in 2015. States performing plan management functions in an FFM may use a similar approach, but are not required to do so. For certification as a QHP in the 2015 benefit year, CMS stated it would **not** use issuer accreditation status to determine network adequacy requirements are met. Instead, provider networks will be assessed using a “reasonable access” standard. In its evaluation of network adequacy in QHPs for the 2015 benefit year, CMS focused on those areas it stated have most typically raised network adequacy concerns:

- Hospital systems;
- Mental health providers;
- Oncology providers; and
- Primary care providers.

If an inadequate network is identified through the QHP certification process, CMS stated it would notify the issuer of the problem and would consider the issuer’s response in its final assessment. CMS also will share information and analysis and coordinate with states conducting network adequacy reviews.

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In addition, CMS indicated it will include time and distance or other standards for FFM QHP networks in future rulemaking. Information gathered during the 2015 benefit year QHP certification process will be used to develop this analysis. Beyond QHP certification, CMS said it also intends to monitor network adequacy via complaint tracking to determine whether QHPs continue to meet network adequacy certification standards.

CMS also stated it will evaluate whether QHPs sufficiently incorporate ECPs into their networks by using a general ECP enforcement guideline requiring plans to include at least 30 percent of available ECPs in each plan's service area in order to participate in the provider network. In addition, the issuer must offer contracts in good faith to:

- All available Indian health providers in the service area; and
- At least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.



## NAIC Managed Care Plan Network Adequacy Model Act



As previously discussed, in 1996, the NAIC adopted the Managed Care Plan Network Adequacy Model Act to “establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility and quality of health care services offered under a managed care plan....”<sup>28</sup> The Model Act provides regulatory guidance to state insurance departments and other agencies with oversight responsibilities for managed health care regulation. The Model was drafted to apply generally to all types of managed care plans, including both HMOs and PPOs, with state regulators/legislators responsible for making modifications as necessary to conform to specific state regulatory structure. Drafting notes are included throughout the document to advise states of specific revisions for consideration.

Earlier this year, the NAIC acknowledged the need to modernize the Model Act and created the NAIC subgroup to work with stakeholders to develop recommendations for consideration by the NAIC. The NAIC stated it intends to “fast track” the process for revising the Model law, with the expectation of completing its work by the end of this year so that it will be available to state and federal policymakers as they consider regulatory changes for the 2016 plan year. Following is an overview of the current Model Act. However, note that while some states have enacted requirements that are similar to provisions included in the Model, very few states have enacted the Model in its entirety.

### Network Adequacy Standards

The Model Act includes the following standards for network adequacy:

- Health carriers must maintain a network that provides a sufficient number of providers to ensure services are accessible without unreasonable delay.
- Emergency services must be available 24 hour a day, 7 days a week.
- Sufficiency may be determined by the carrier based on (but not limited to) the following criteria:
  - o Provider-to-enrollee ratios for primary care and/or specialty care;
  - o Geographic accessibility;
  - o Waiting times for appointments;
  - o Hours of operation;
  - o Volume of technological and specialty services available to meet enrollee needs.
- If a carrier’s network does not have a sufficient number or type of providers to provide a covered benefit, the carrier must work with the enrollee to obtain the care elsewhere at no greater cost to the enrollee. As an alternative, the health plan can make other arrangements acceptable to the regulatory agency.

- Enrollees must have access to providers that are within a reasonable proximity to their business or personal residence. Regulators are instructed to give consideration to the availability of providers within the service area in determining compliance with this provision.
- Health carriers are required to continually monitor their ability – including clinical capacity – to furnish all contracted benefits to enrollees.
- Carriers must file an access plan with the regulatory agency, in a form defined by the regulator. The plan must be updated when the carrier makes any material change to the plan. The plan must include:
  - o The carrier's network;
  - o Procedures for making referrals within and outside the network;
  - o The process for monitoring network sufficiency;
  - o How the carrier will address needs of enrollees with limited English proficiency, cultural and ethnic diversities, and individuals with physical or mental disabilities;
  - o A process for assessing the ongoing needs of enrollees and customer satisfaction;
  - o A process for informing enrollees of plan benefits and requirements, such as grievance procedures; the process for choosing and changing providers; and the process for providing and approving emergency and specialty care;
  - o A system for ensuring coordination and continuity of care for enrollees referred to specialty physicians and persons using ancillary services (including social services and other community resources) and for discharge planning;
  - o The health plan's process for allowing enrollees to select and change primary care providers;
  - o A continuity of care plan when a participating provider's contract is terminated for any reason, or if the health carrier becomes insolvent or is unable to continue operations for any reason;
  - o Any other information required by the regulating entity.

## Health Carrier and Participating Provider Requirements

The Model Act includes the following requirements for health carriers and participating providers:

- Contracts between carriers and providers must include a hold harmless provision that prohibits the provider from seeking payment for services from an enrollee if the health carrier fails to pay the provider for covered services provided to an enrollee. The restriction does not apply to coinsurance, deductibles or copayments or costs for uncovered services delivered on a fee-for-service basis to an enrollee, provided the enrollee is clearly informed that the carrier may not cover the specific service and agrees prior to treatment to pay for the services;
- The carrier's selection standards for including providers in the network must meet requirements equivalent to the Health Care Professional Credentialing Verification Model Act and cannot:
  - o Allow a carrier to avoid high-risk enrollees by excluding providers located in areas that serve populations with a risk of higher than average claims, losses or health care utilization, or
  - o Exclude providers solely because they treat patients with a risk of higher care costs or health care utilization.<sup>29</sup>
- The carrier must provide the regulating entity a copy of its selection standards for participating providers.<sup>30</sup>
- The carrier may not prohibit providers from discussing any treatment options with the enrollee, or from advocating on behalf of the patient in a utilization review or grievance process;
- Provisions regarding contract terminations, including at least 60 days notice to either party before terminating the contract without cause.
- Carriers must provide notice to enrollees when terminating a primary care provider.
- Providers may not assign or transfer their rights and responsibilities under a contract without consent of the carrier.<sup>31</sup>
- Providers are obligated to provide covered services regardless of whether the plan is a public program or private plan.

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The Model Act includes a number of additional administrative and contractual obligations designed to protect both the carrier and the provider, including notification of the provider's administrative and financial responsibilities, prohibition against penalizing providers for reporting carrier activities that jeopardize a patient's health, and dispute procedures between carriers and providers.

### **Requirements for Intermediary Arrangements**

The Model Act also includes requirements for agreements between health carriers and intermediaries who are authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network. The provisions are primarily administrative responsibilities related to documentation, maintenance and availability of information and records. The Model Act also allows the carrier to approve or disapprove participation of a subcontracted provider in its own or a contracted network. Intermediaries must comply with all of the requirements outlined above and included in Section 6 of the Model Act.

### **State Filing and Contracting Requirements**

The Model Act includes several additional procedural or administrative provisions under Section 8 and 9, including a requirement that carriers file sample provider contracts with the state and a statement that the execution of a contract with a provider does not relieve the carrier of its responsibilities or liabilities under state law.

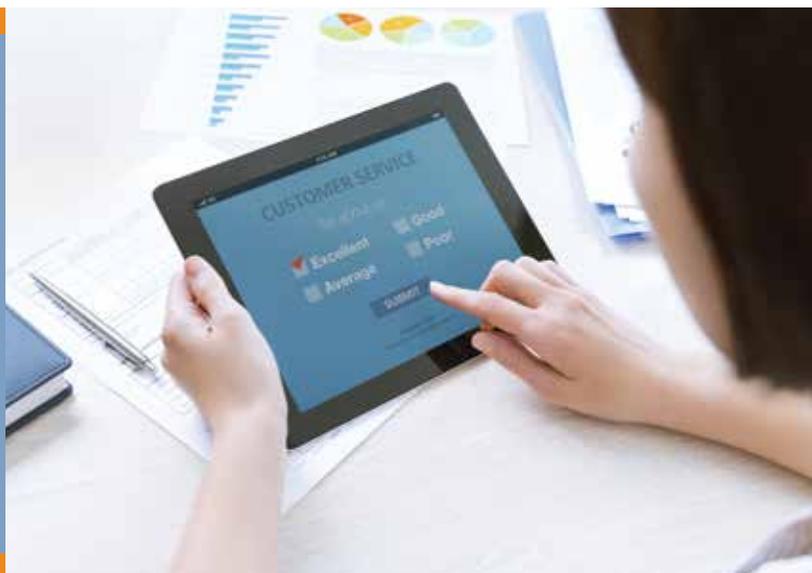
### **Enforcement**

If the Commissioner or regulating entity determines a carrier has failed to meet the network adequacy standards or violates another provision of the Model Act, a corrective action plan should be developed by the carrier, or other appropriate enforcement action should be taken to ensure compliance.

The Model Act also prohibits the regulatory agency from acting to arbitrate, mediate or settle disputes regarding a carrier's decision not to include a provider in the network, or any other dispute regarding provider contracts or termination.



# Survey of State Regulators' Network Adequacy Oversight Activities and Regulations



Although states have taken a range of approaches to network adequacy oversight based on variations in statutory authority, local market conditions, geographic factors and managed care prevalence rates, all states share common problems and concerns and have successfully used the NAIC as a forum to discuss aligning regulatory requirements across states when appropriate. The appointment and subsequent activities of the NAIC Network Adequacy Model Review Subgroup is an excellent example of the NAIC's efforts to include stakeholders in the development of solutions to problems associated with Network Adequacy, and the Consumer Representatives welcome the opportunity to participate in this initiative.

In May 2014, the NAIC Consumer Representatives sent a letter to the DOIs of each state, Puerto Rico and the District of Columbia, requesting completion of a survey to help identify current standards for regulating network adequacy, the challenges regulators face, and some of the tools they have developed to assist them in their oversight of network adequacy. The survey is included as Appendix A. The intent of the survey is to identify various ways regulators monitor and review network adequacy and creative solutions states have developed that could be replicated or reflected in modifications to the Model Law.

The survey questions were divided into two sections. The first section requested information regarding general approaches states have taken to regulating network adequacy in their health insurance market. States were also asked to indicate to what extent they had adopted the NAIC Network Adequacy Model Law. The second section asked for more specific information about how states have operationalized their network adequacy oversight, specifically asking them to distinguish differences in the oversight of network adequacy as it relates to 1)PPOs and 2)HMOs.

**To encourage participation and in recognition of the sensitivity of the issue, states were assured their individual responses would be kept confidential.** States that share managed care oversight with an agency other than the DOI were asked to submit responses from both agencies. Over a three month period, we received 38 surveys, including responses from the District of Columbia and Puerto Rico. Following is a summary of the survey results.

## Survey Part One: General Approaches to Regulating Network Adequacy

### Use of NAIC Model Act

States were asked whether they had adopted the NAIC Model Act, and if so, whether it was adopted in its entirety or modified. Of the 38 respondents, seven indicated that the NAIC Managed Care Plan Network Adequacy Model Act was adopted as written, while two indicated they had adopted portions of the Act, but with significant revisions. The remaining 29 respondents indicated they had not adopted the NAIC Model Act.

**TABLE 1: STATE ADOPTION OF NAIC MODEL ACT**

	Adopted Model Act	Adopted Model Act, with Significant Revisions	Have Not Adopted Model Act
Percentage of Respondents	18%	5%	76%

### Use of Network Adequacy Complaint Codes

The inclusion in state DOI complaint tracking systems of complaint codes specifically related to network adequacy indicates to what extent regulators are able to identify complaints related to network adequacy or access to care. Because complaint data is an important enforcement mechanism for regulators, more detailed data will better equip states to monitor health plan compliance and identify potential problems in their earliest stages. Survey respondents were provided 10 specific complaint codes and asked to identify those that are included in their complaint tracking systems:

- a. Inadequate Provider Network
- b. Network Adequacy
- c. Access to Care
- d. Timely Access to Care
- e. Inaccurate Provider Directory
- f. Out-of-Network Claim Dispute/Resolution
- g. Out-of-Network Services
- h. Formulary Restrictions
- i. Balance Billing
- j. Other

Almost all respondents indicated that one or more of the listed complaint codes related to network adequacy or access to care are included in their current complaint tracking systems. Only one of the 38 respondents indicated they did not include any complaint codes related to network adequacy or access to care in their complaint tracking systems. On average, states include five of the 10 complaint codes listed above. Table 2 summarizes the percentage of states indicating they use a particular complaint code, or one with a very similar description, in their tracking systems.

**TABLE 2: DOI USE OF NETWORK ADEQUACY COMPLAINT TRACKING CODES**

Complaint Code Option	Adopted Model Act
a. Inadequate Provider Network	63%
b. Network Adequacy	34%
c. Access to Care	76%
d. Timely Access to Care	29%
e. Inaccurate Provider Directory	50%
f. Out-of-Network Claim Dispute/Resolution	47%
g. Out-of-Network Services	66%
h. Formulary Restrictions	21%
i. Balance Billing	34%
j. Other	42%

In addition to the codes listed in the table, respondents reported using the following additional “other” codes for tracking network adequacy or access to care complaints:

- Provider availability;
- Choice of primary care provider;
- Provider listing dispute;
- Pharmacy benefits (similar to formulary restrictions);
- Essential community providers;
- Appointment availability;
- Out-of-Network emergency care;
- Access to OB/GYN;
- Network denial/termination of provider;
- Claims reimbursement/balance billing issuers;
- Out-of-Network referral;
- Inadequate network rates;
- Primary care physician referral;
- Closed network/provider discrimination;
- Credentialing delay;
- Delayed authorization issue; and
- Access to fee schedule rates.

## Biggest Challenges Faced in Oversight of Network Adequacy

Respondents were asked to rate the challenges they face in the regulation and oversight of network adequacy. Options included:

- Maintaining adequate trained staff for network analysis activities
- Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure
- Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved
- Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services
- Lack of authority to exercise increased oversight and impose enforcement actions and penalties
- Additional challenges encountered

Respondents were asked to rate these challenges on a scale of 1 to 5 (with 1 as the least significant and 5 as the most significant). Respondents were instructed to rate each challenge individually rather than rating them in relation to one another. Of the 38 responses, eight did not rate the challenges. Of the respondents that did rate these challenges, the highest rated challenge was “Ensuring health plan enrollees have sufficient information to understand the risks and potential costs of receiving out-of-network services.” On average, the other regulatory and oversight activities related to network adequacy were scored equally challenging by respondents. See Table 3 for a summary of results.

**TABLE 3: NETWORK ADEQUACY REGULATORY CHALLENGES**

Challenge to Regulating Network Adequacy	Average rating (1 is least significant and 5 is most significant)
a. Maintaining adequate trained staffing levels for network analysis activities	3
b. Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure	3
c. Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved	3
d. Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services	4
e. Lack of authority to exercise increased oversight and impose enforcement actions and penalties	3

Other challenges identified by respondents include:

- Insufficient funding/resources
- Lack of providers and significant unwillingness of specialty providers to contract with insurers
- Issues of disclosure for nonparticipating facility-based providers

- Geographic challenges
- Educating consumers about the shift to EPOs
- Ensuring network adequacy throughout the year
- Different requirements and/or regulatory authority for HMOs vs PPOs
- Oversight bifurcated between different regulatory entities
- Confusion among health plans around provider contracts, including which providers they contract with, what services those providers perform and what networks those providers are a part of; additionally on the provider side, providers are unclear about which health plans they contract with and in which networks they are a participating provider.

## Role of State Regulators in Ensuring Consumers Are Informed about the Impact of Seeing Out-of-Network Providers

The survey asked regulators to indicate whether they have any requirements for health plans to include notifications to members to ensure they are adequately informed of the circumstances in which a member may see an out-of-network provider and how to avoid doing so. The majority of respondents (61 percent) indicated they do have requirements, but the provisions vary. States report health plans must use one or more of the following documents for notification requirements:

- Evidence of coverage documents;
- Plan description;
- Health care contracts;
- Marketing documents;
- Policy forms and certificates of coverage;
- Member handbooks; and
- Separate disclosure notices related specifically to balance billing.

## Transparency Requirements to Protect Consumers When Facility-Based Physicians Providing Care in an In-Network Hospital are Out-of-Network

Respondents were asked whether there were any “transparency” requirements in place designed to prohibit or limit circumstances when a facility-based physician (e.g., anesthesiologist, radiologist, ER physician) is unavailable to the patient, even when the facility is in the patient’s network. Of the 37 responses, the states were almost evenly split with 51 percent reporting they have no transparency requirements and 49 percent that do.

**TABLE 4: TRANSPARENCY REQUIREMENTS REGARDING SERVICES OF OUT-OF-NETWORK PROVIDERS**

	Yes	No
Does your state have “transparency” requirements or network adequacy provisions in place to prohibit or limit circumstances when no facility-based physician is available, even though the hospital/facility is in the patient’s network?	49%	51%

In the detailed information they provided, respondents report using a variety of strategies to ensure consumers are protected in these types of situations, including:

- Require health plans to provide benefits at in-network cost sharing levels for out-of-network facility-based providers or to hold consumers harmless for charges over and above the in-network rates
- Require health plans to comply with claims payment standards for determining payment amounts for non-network providers for HMO plans
- Require health plans to track and report to DOI the amount of out-of-network claims submitted for services provided at in-network facilities

- Require health plans and providers to participate in mandatory arbitration to negotiate and resolve out-of-network balance bills
- Require health plans to hold consumers harmless for any costs for out-of-network emergency services that exceed what the consumer would have paid to an in-network provider.

In addition, some states also require facilities to notify the health plan when a surgery is scheduled for which an in-network provider may not be available. Others reported that the burden is on the consumer who is required to contact the anesthesiologist, radiologist, pathologist, facility, clinic, or laboratory when scheduling appointments or elective procedures to determine whether the provider is in-network.

## Reporting Requirements for Network Adequacy Oversight

Respondents were asked to rate the extent to which they believe a list of current requirements for regular reporting of the following health plan data are important, or would help in the oversight and monitoring of network adequacy if they were required. Respondents were asked to separately rate each provision on a scale of 1 to 5 (with 1 as the least significant and 5 as the most significant). Of the 38 respondents, six did not respond to the question. Of the remaining 32 responses, the three highest rated responses (e, f, g) indicate regulators highly value consumer complaint data as a mechanism for monitoring network adequacy. Complete results are included in the following table.

**TABLE 5: IMPORTANCE OF HEALTH PLAN DATA REPORTING REQUIREMENTS**

Importance of requirement for regular reporting of health plan data (either existing or hypothetical) for regulating network adequacy	Average rating (1 is least significant and 5 is most significant)
a. Aggregated data on number/percentage of out-of-network claims	3
b. Data on number/percentage of out-of-network claims by service area	3
c. Claims value of out-of-network claims	2
d. Reimbursement rate payments for in-network claims vs. out-of-network claims	2
e. Number of complaints filed with health plan regarding problems accessing care, receipt of care by out-of-network providers, or claims payment of out-of-network services	4
f. Number of complaints filed with health plan regarding inaccurate provider directory information	4
g. Number of complaints filed with health plan regarding restriction of provider access due to enrollment in a narrow network	4

## Survey Part Two: Operational Processes Related to Regulatory Oversight of Network Adequacy

This section of the survey requested information on the processes regulators use to review and monitor network filings and other information used to evaluate compliance with network adequacy requirements. Because requirements frequently vary for HMO and PPO plans, respondents were instructed to provide separate responses for the two types of plans. Following are the results of these questions.

### Health Plan Network Review

Respondents were asked to identify at which of the times provided below they review a health plan's network for compliance:

- Upon application for licensure
- When adding a new service area or expanding an existing area
- Regularly scheduled periodic review (i.e., annually, semiannually, biennially, etc.)
- When complaints or other market conduct oversight activities indicate a potential problem
- Routinely required as part of a market conduct examination
- When a health plan files a notice of significant change to their network
- Other

Of the 38 survey respondents, five did not identify any circumstances under which they review HMO or PPO networks. Of the remaining 33, as expected, the responses in Table 6 indicate regulators are much more likely to review HMO networks than PPO networks both initially and as part of ongoing oversight activities. Consistent with other information provided by respondents, regulators typically rely on complaint data for both HMOs and PPOs to trigger a review of the network.

**TABLE 6: CIRCUMSTANCES REQUIRING HEALTH PLAN NETWORK REVIEWS**

Circumstance under which Department reviews health plan network	HMOs	PPOs
a. Upon application for licensure	85%	36%
b. When adding a new service area or expanding an existing area	73%	36%
c. Regularly scheduled periodic review	42%	36%
d. When complaints or other market conduct oversight activities indicate a potential problem	85%	67%
e. Routinely required as part of a market conduct examination	39%	27%
f. When a health plan files a notice of significant change to their network	70%	42%
g. Other	9%	6%

One state that reported “Other” noted that the DOI may initiate a review of an HMO’s network based on complaints. However, for PPOs, the DOI’s investigations are limited to transparency issues, communications provided to PPO members and how information is different from care received, or how the information was provided. The state does not have network adequacy requirements for PPOs.

### GEO-Access Maps

In answering whether GEO-Access maps are required as part of the provider network filing, 45 percent of the 38 respondents indicated that GEO-Access maps or their equivalent are required of HMO plans, compared to 29 percent who have similar requirements for PPOs.

**TABLE 7: HEALTH PLAN GEO-ACCESS MAPPING REQUIREMENTS**

	Yes for HMOs	Yes for PPOs
Does your Department require plans to submit GEO-Access maps or equivalent as part of their provider network filing?	45%	29%

### Use of Vendors in the Review and Analysis of Provider Network File Submissions.

Respondents were also asked whether their Department contracts with a vendor for the review and analysis of provider network file submissions. Of the 38 respondents, four (11 percent) reported they use vendors to review and analyze provider network file submissions for both HMO and PPO plans.

### Initial Provider Network Review

Respondents were asked to identify the types of information reviewed as part of the initial provider network review process. A list of seven common types of data was included and are listed in Table 8 below. Of the 38 total survey respondents, 28 responded to the question. Consistent with other survey responses, regulators report that HMOs are more likely than PPOs to be subject to more extensive reviews in all categories listed.

**TABLE 8: DATA REVIEWED DURING INITIAL NETWORK ADEQUACY REVIEW**

Information reviewed as part of initial provider network review process	HMOs	PPOs
a. The entire filing is reviewed in detail and tested against GEO Access standards to determine full compliance	50%	36%
b. A sample of the network data files are reviewed in lieu of a full, comprehensive assessment of the network	11%	4%
c. The state accepts the health plan’s attestation that the network filing complies with the Department’s requirements	39%	29%
d. Department staff perform “secret shopper” calls to confirm providers are in the network and accepting new patients	11%	0%
e. Medical care referral patterns and hospital admission privileges are reviewed to ensure participating providers have admitting privileges at in-network facilities	11%	7%
f. Department staff verifies whether in-network hospitals contract with facility-based providers (i.e., radiologists, pathologists, anesthesiologists, emergency room physicians) who are in the health plan’s network	21%	14%
g. Network providers are reviewed to determine whether the network includes access to centers of excellence for transplants, cancer, and other critical services	36%	29%

### Ongoing Network Adequacy Oversight

To further evaluate regulatory approaches for ensuring network adequacy once a health plan’s network has been filed and reviewed, respondents were asked to identify from a list of options which activities the Department uses to monitor network adequacy on an ongoing basis. Twenty-seven of the 38 survey respondents provided an answer. Survey responses indicate that most Departments monitor ongoing compliance with network adequacy requirements by evaluating trends or particular issues identified through complaint data. Again, consistent with previous information, regulators report that they commonly rely on complaint data to identify network adequacy issues in both HMO and PPO markets. Regulators also indicate they are slightly more likely to exercise more stringent oversight of narrow networks in PPO plans than in HMO plans, but even so, only three states use this tool to conduct additional oversight of PPOs.

**TABLE 9: INFORMATION USED BY REGULATORS TO MONITOR ONGOING NETWORK ADEQUACY**

Information used to monitor ongoing network adequacy	HMOs	PPOs
a. Department collects out-of-network data from health plans to identify the extent to which members use out-of-network services	15%	11%
b. Department exercises more stringent oversight and monitoring of “Narrow Networks” that offer a more restricted network in exchange for reduced premium rates	7%	11%
c. Department monitors health plan members’ ER utilization as a possible indicator of an inadequate network	4%	4%
d. Department reviews health plan consumer satisfaction surveys to identify the extent to which enrollees report dissatisfaction with the network or access to care	19%	11%
e. Department performs random survey of providers to confirm providers are in network, accepting new patients, confirm appointment availability timeframes, or other relevant information	19%	19%
f. Department monitors complaints to identify trends or concerns that could indicate potential problems with network adequacy	85%	70%
g. Department requires health plans to report complaint information on volume of complaints related to network adequacy/access to care	30%	26%

Several states provided information describing additional monitoring activities they use, including:

- Health plans are required to become reaccruited with any service area expansion or material change in the provider network (HMOs).
- Some components of network adequacy are reviewed annually or semi-annually, including:
  - o Provider directory (both printed and web-based) updates to determine accuracy, and
  - o Data related to access and availability of appointments.
- Network adequacy is sometimes reviewed as part of market conduct exams.

## Protecting Consumers from Out-of-Network Charges

To evaluate how consumers are protected from out-of-network charges or balance billing, we asked respondents to identify whether they have adopted certain regulatory requirements for either HMO or PPO plans. Thirty of the 38 respondents identified one or more provisions are applicable in their state.

The most commonly used strategy requires plans to pay for out-of-network emergency services in a way that protects enrollees from costs that would exceed the cost of care provided by an in-network facility. However it should be noted that some states interpreted this question differently than others. Several responded “Yes” to the question but pointed out that they require plans to pay out-of-network claims in a way that limits the percentage of an enrollee’s co-insurance payment, but not the total amount of the coinsurance. For example, a 20 percent coinsurance on a \$500 in-network claim is \$100. If the service is out-of-network and the fee is \$1,000, the consumer still must pay the 20 percent coinsurance on a \$1,000 charge, or \$200 instead of the \$100 required for an in-network provider. Although not all states that responded affirmatively to this question provided clarification, based on other responses in the survey, it appears likely that this practice is common in other states.

**TABLE 10: STATE REGULATION OF OUT-OF-NETWORK CHARGES**

What strategies apply to protect consumers from out-of-network charges?	HMOs	PPOs
a. Plans are required to resolve/pay claims for out-of-network emergency services in a way that ensures enrollees’ costs are no more than what they would be for in-network services	83%	60%
b. Plans are required to calculate claims payments for emergency out-of-network services based on specific criteria or a formula specified by statute or regulation	33%	30%
c. Plans are required to calculate claims payments for non-emergency out-of-network services based on specific criteria or a formula specified by statute or regulation	13%	17%
d. Health plans are required to comply with general criteria (such as usual, customary and reasonable) in the calculation of out-of-network claims payments	43%	47%
e. Consumers are entitled to an independent arbitration process for negotiating health plan payments for out-of-network services	7%	13%

## Provider Directory Oversight

Respondents were asked to provide information about oversight mechanisms used to ensure accuracy of provider network directories. Respondents were asked to choose any that apply from the following list:

- a. Printed network directories must be updated at least semi-annually
- b. Printed network directories must be updated at least annually
- c. On-line directories must be updated at least monthly
- d. On-line directories must be updated at least quarterly

- e. For health plans that offer tiered or narrow networks that include a subset of providers, directories must clearly identify which providers participate in the restricted/narrow network
- f. If a consumer relies on inaccurate information in a directory and is balance billed as a result, the health plan is responsible for resolving the claim in a way that holds the patient harmless

Twenty-one respondents answered this question. Compared to other types of regulatory oversight identified in the survey, states appear to more consistently apply similar criteria for both HMOs and PPOs.

**TABLE 11: NETWORK DIRECTORY REQUIREMENTS**

Network directory requirements	HMOs	PPOs
a. Printed network directories must be updated at least semi-annually	14%	5%
b. Printed network directories must be updated at least annually	48%	38%
c. On-line directories must be updated at least monthly	29%	24%
d. On-line directories must be updated at least quarterly	14%	14%
e. For health plans that offer tiered or narrow networks that include a subset of providers, directories must clearly identify which providers participate in the restricted/narrow network	62%	62%
f. If a consumer relies on inaccurate information in a directory and is balance billed as a result, the health plan is responsible for resolving the claim in a way that holds the patient harmless	43%	43%

### Network Adequacy Enforcement Actions

Respondents were asked to identify the average annual number of enforcement actions (e.g., fines, penalties, cease and desist, enrollment freeze, licensure revocation) taken in response to network adequacy violations. Five respondents did not answer this question. Responses of the remaining 33 respondents are provided in Table 10. On average, most respondents report the number of enforcement actions related to network adequacy is very low, with 88 percent of respondents indicating 0-1 enforcement actions are pursued on average each year for HMOs, and 73 percent indicating 0-1 enforcement actions are pursued on average each year for PPOs.

**TABLE 12: AVERAGE NUMBER OF ENFORCEMENT ACTIONS TAKEN IN RESPONSE TO NETWORK ADEQUACY CONCERNS**

Average annual number of enforcement actions related to network adequacy violations	HMOs	PPOs
a. 0-1	88%	73%
b. 2-3	3%	0%
c. 4-5	0%	0%
d. 5-10	0%	3%
e. 11 or more	3%	3%
f. Do not know	6%	6%

### Network Adequacy Requirements for POS and/or EPO Plans

Given the increasing use of different types of network plans to keep premium costs low, respondents were asked to provide information about how network adequacy is regulated for Point of Service (POS) plans and/or EPOs.<sup>32</sup> Twenty-five states replied to the question. In the majority of states, both POS plans and EPOs are subject to some level of oversight, but the approach varies among states. POS plans are more likely to be subject to HMO than PPO standards for regulatory purposes, while EPOs are equally likely to be subject to either PPO or HMO standards, depending on the state. However, five states reported POS plans are not subject to any network adequacy requirements, and four states have no network adequacy requirements for EPOs. Of the states that reported “Other,” two noted that EPOs are not allowed and one state noted that network adequacy requirements do not apply to POS plans or EPOs. One other state noted that all plans (HMOs, PPOs, EPOs, POS) are subject to the same network adequacy standards as outlined in the ACA market reforms.

**TABLE 13: HOW STATES REGULATE POS AND EPO PLANS**

Regulatory approach for POS and/or EPO benefit plans	Percentage indicating regulatory approach is taken
a. POS plans are not subject to network adequacy requirements	20%
b. EPOs are not subject to network adequacy requirements	16%
c. POS plans are subject to the same network adequacy requirements that apply to PPOs	56%*
d. POS plans are subject to the same network adequacy requirements that apply to HMOs	76%*
e. POS plans are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs	4%
f. EPOs are subject to the same network adequacy requirements that apply to PPOs	44%
g. EPOs are subject to the same network adequacy requirements that apply to HMOs	44%
h. EPOs are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs	4%
i. Other (please describe)	20%

\*Some states responded that POS and EPO plans are subject to the same standards as both PPOs and HMOs, which results in responses that total more than 100%. Based on additional information provided by several states, requirements vary depending on whether the POS or EPO plan is offered by an HMO or a PPO. If offered by a PPO, the plan is subject to the PPO standards. If offered by an HMO, the plan is subject to the HMO standards.

## Survey Highlights and Recommendations for Improving Network Adequacy Oversight

In addition to providing a better understanding of the tools states use – or don’t use - to regulate network adequacy, the survey results identify opportunities for improved regulations and suggest revisions to include in the NAIC Model Act update to improve network adequacy oversight and consumer protections. While several recent studies provide a good overview of existing statutory or regulatory provisions adopted by states, this survey looks beyond the regulations to obtain regulators’ perspectives on how the provisions work in “the real world,” challenges they face in their efforts to oversee network adequacy, and ideas for improvements. Although not all states participated in the survey, the responses represent states of varying sizes, from all regions of the country, and with varying levels of network plan penetration rates. While the identities of the responding states are not being made publicly available in order to encourage states to provide honest, frank answers, the 73 percent response rate is a testament to the importance of this issue and the interest states have in contributing to the NAIC’s efforts to improve the Model Act.

### Key findings include:

- Most states have not adopted the NAIC Managed Care Plan Network Adequacy Model Act.
- States place a high value on consumer complaint data and commonly rely on complaint data as a tool for identifying potential problems and monitoring health plan compliance. However, the codes they use for identifying network adequacy complaints vary widely. Only three of the complaint code options provided in the survey are used by more than half of the surveyed states. As such, the ability to share information with neighboring states, where consumers may also seek care and file complaints regarding access problems, is limited. In addition, the more restrictive codes used by some states may fail to fully identify the types of problems consumers have and could limit the usefulness of the information.
- States identified several common challenges in their efforts to oversee network adequacy. While the challenge most commonly identified is ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services, other objectives pose equal challenges for some states (maintaining adequate staffing levels, obtaining complete and accurate data files from health plans, monitoring and identifying network adequacy problems, lack of authority to exercise increased oversight and take enforcement action). Four states reported all five areas of oversight at the highest level of challenge; two other states identified four of the five areas at the highest level. These data seem to confirm that disparate approaches to regulation and the varying degrees to which states have access to common regulatory tools create inconsistencies in the protections available to consumers based in part on where they live.

- More than half of the states do not prohibit or limit a situation in which a member receives services from an out-of-network provider when being treated at an in-network hospital.
- While HMO and PPO benefit plans have distinct coverage provisions that justify some differences in regulatory oversight, states consistently exercise much more stringent oversight of HMO plans than PPO plans. For example, while 24 states require HMO plans to resolve or pay claims for out-of-network emergency services in a way that protects enrollees from balance billing, only 16 states impose similar requirements on PPO plans. Seven states indicated such protections do not exist for either PPO or HMO plans.
- Information included in regulators' review of network filings also varies significantly. Only 14 states review the entire filings for HMO plans and 10 do so for PPOs. States that do not perform comprehensive reviews miss important opportunities to identify problems up front, before they become a problem.

## Recommendations

Based on these findings, as well as information provided in other relevant studies, we have included the following recommendations for updating the NAIC Model Act, as well as for consideration by states as they evaluate their own legal framework for overseeing network adequacy. Please note that these recommendations are limited to only those requirements that are within the jurisdiction and control of regulators and network plans. However, the problems of network adequacy and balance billing are not solely attributed to health plans but are shared by providers, including hospitals and other facilities and practitioners. Until collaboration among all parties occurs, regulators must rely on the enforcement and regulatory authority they have to ensure consumers receive the services they are entitled to under the terms of their insurance contracts and have the information they need to make informed decisions regarding the health plan they purchase and health care services they receive.

### Expand Scope of Regulations to Include All Network Plans

To most effectively regulate network adequacy across all products currently available to consumers, the Model Act and state regulations should broadly apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others (e.g., HMOs, EPOs, PPOs, POS, accountable care organizations), and any other new model of care delivery. The NAIC and DOIs should also establish a process for regularly reviewing existing standards and make necessary revisions to ensure they are applicable to new managed care models that evolve over time.

### Quantify Reasonable Access Standards

To ensure a meaningful and transparent network adequacy “floor”, network adequacy regulations should include meaningful quantitative provider-to-enrollee, travel time and distance, and appointment wait time standards as benchmarks for measuring network adequacy. Health plans should also be required to meet a minimum cultural appropriateness standard that ensures enrollees of different ethnic and cultural backgrounds have access to a diverse group of providers. The Model Act should incorporate flexibility to allow states to include standards that take into account their particular geographic factors, regional provider workforce shortages, and market conditions. While variations from state to state are necessary in the current environment, many states do not have even minimum standards, but instead allow health plans to self-define what they consider to be reasonable access. As a general rule, network access standards should ensure that all covered benefits can be provided through an in-network provider without an unreasonable delay and that health plans meet a standard for providing access to a culturally diverse network of providers. Limited exceptions may be included to address cases where sufficient numbers of certain types of health care providers are not available due to workforce shortages, the use of Centers of Excellence or similar types of arrangements for elective procedures, or to care for patients with particularly complex medical conditions. However, in such cases, provisions must also be included to ensure enrollees have access to non-network providers at no increased cost.

### Ensure Consumer Choice between Broad, Narrow, or Ultra-Narrow Networks

A state regulatory agency should have discretion to determine whether consumers have adequate choice between broad, narrow, or ultra-narrow networks and, in areas where sufficient choice is not available, require a carrier to offer at least one plan with a broad network or an out-of-network benefit, unless the carrier can demonstrate good cause that such an option is not feasible. Furthermore, consumers must be provided with information that conveys, in a consumer-tested standardized way, the narrowness or broadness of a provider network at the point of shopping. The accuracy of these summary measures must be audited by the regulator.

## Include Essential Community Providers

All plans should be required to include access to Essential Community Providers to increase consistency with ACA requirements, prevent adverse selection, and to support continuity of care for those new enrollees who already have an existing relationship with an ECP.

## Expand Access Plan Filing Requirements to Improve Transparency

Carriers should be required to submit access plans to the regulating entity for prior approval and post approved plans on a public website for review by consumers. In addition to requirements in the current Model Act for access plans, the following components should also be added using a uniform format to ensure transparency and comparability among plans:

- Carrier’s criteria for selecting network providers, including measures related to standards for quality of care and health outcomes;
- Carrier’s protocol for maintaining, updating, and publicly posting its directory of participating providers specific to each network plan, including whether providers are accepting new patients, languages spoken in each provider office, and provider office hours and locations; and
- Carrier’s method for publicly conveying breadth or narrowness of the provider network and the method of selecting network providers for each network plan. Information must be displayed in a standardized manner that allows consumers to compare provider networks across carriers and benefit plans.

These requirements may be adjusted to reflect any minimum standards the DOI has established related to each of these provisions.

## Protect Consumers from Balance Billing

In all network plans, require carriers to include a provision in network provider contracts to protect consumers from balance billing under certain conditions, including for any services provided in a facility that is a network provider but uses out-of-network health care professionals to provide patient services. To accommodate exceptions for consumers who choose an out-of-network provider, health plan enrollees should be allowed an opportunity to authorize – in writing and in advance of receipt of services – that they have **knowingly chosen** to be treated by an out-of-network provider and have been informed of the potential costs of doing so.

In addition (or in lieu of for any state that fails to enact a prohibition against balance billing), require health plans and providers to participate in mandatory arbitration to reach agreement on a reasonable payment for out-of-network services. Under arbitration, consumers should be held harmless for any costs that exceed what they would have paid if the provider had been in-network.

## Work with Other Agencies to Address Balance Billing

While we recognize that DOIs may not have the authority to regulate providers that do not have a contract with a health plan, we encourage DOIs to work with other state agencies that do regulate providers to put in place greater transparency and additional balance billing protections for consumers. In the event a DOI is unable to enact regulations protecting consumers from balance billing (see previous recommendation), if a health plan enrollee is balance billed for out-of-network services, a mandatory binding mediation process should be required to resolve bills that exceed a certain threshold. Mediation attendees should include the provider and a health plan representative. States should establish a reasonable threshold for consumers to request mediation when bills exceed a certain level. New York’s new “surprise bills” law and Texas’ mediation requirements can serve as a model for other states on this important concern.

## Require Providers to Notify Health Plans when Leaving a Network for Any Reason

To ensure health plans have accurate information on the status of network providers, require health plans to include in all provider contracts a requirement that providers notify the plan and their patients when they are leaving a network for any reason. This may include but is not limited to a decision to retire or stop practicing medicine for other reasons, relocating to an area outside the health plan’s service area, leaving a group practice that is included as a participant in the network, or withdrawing from a network for any other reason. Health plans should be required to update electronic provider directories at least monthly to reflect these and other changes in provider availability.

## Ensure Continuity of Care

In situations where a carrier and a participating provider terminate their contract or the provider is assigned to a different cost-sharing tier, the carrier and provider should be required to provide continuing coverage for a covered person who is pregnant, terminally ill, or in the midst of an active course of treatment for a serious medical condition for 90 days, or until the course of treatment is completed, whichever is longer, under the same cost-sharing rules and provider negotiated rate that would apply if the contract or tier placement was still in force.

In addition, circumstances for special enrollment periods should be expanded to allow enrollees to switch health plans when any of the following triggering events occur:

- An individual's enrollment or non-enrollment in a plan is the result of a material error, inaccuracy, or misrepresentation in the provider directory, including but not limited to a provider being listed as a participating provider that is not part of the network or a provider incorrectly being listed as accepting new patients;
- A covered person's primary care provider becomes a non-participating provider during a plan year or policy year; or
- A covered person who is in the midst of a course of treatment for pregnancy or a serious medical condition loses access to their specialty care provider or facility because the provider becomes a non-participating provider or is moved to a higher cost-sharing tier during the plan or policy year.

## Increase Transparency Requirements

DOIs should require that health plan provider directories be made publicly available and ensure that consumers can easily understand which provider directory applies to which network plan, if a carrier maintains more than one network. The provider directory should be available online to both enrollees and consumers shopping for coverage without requirements to log on or enter a password or a policy number and should include the following general information about the plan:

- The type of plan (e.g., HMO, PPO, EPO) and whether there is any coverage for services provided by out-of-network providers;
- The methodology used, if any, to determine the payment amount for out-of-network services;
- The breadth of the network, as defined by the commissioner or NAIC model (i.e., broad, narrow, or ultra-narrow);
- The standards or criteria for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier; and
- The plan's protocol for using out-of-network providers with in-network cost sharing for situations where a suitable in-network provider is not available on a timely basis.

Health plans should also include transparency information in the Member handbook and on the health plan's public website in a location and format to be determined by the Insurance Commissioner.

## Adopt Health Plan Reporting Requirements to Monitor Frequency of Out-of-Network Services

Regulators should adopt standard reporting requirements for all network plans to obtain data on out-of-network claims and more accurately measure network adequacy. For each service area in which the health plan operates, minimum data elements should include the number of out-of-network claims by type of provider, dollar value of total claims, average value per claim, total amount paid by the health plan, average amount paid per claim, total unpaid claim balances and average unpaid claim balance per claim. These data will allow regulators to identify types of providers and/or services that are most frequently the source of out-of-network claims, the adequacy of reimbursement amounts paid by health plans, and the potential financial impact on consumers if the provider balance-bills for the difference between the cost of the service and the amount paid by the health plan. Information should be publicly available on the DOI's website and the health plan's website.

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## **Increase Utility of Complaint Data and Visibility of Complaint Process**

Regulators should identify the most complete and useful set of complaint codes, learning from the wide variety of experience identified by the survey. In addition, regulators need to assess how many consumer problems actually make it into their complaint system. Unfortunately, many consumers don't realize they have a department of insurance and that the department can help resolve their insurance issues. The visibility of this process must be raised via marketing, mandatory notices on provider bills and health plan Explanations of Benefits, and other means. Further, this process must take into account complaint data received by other agencies such as the health insurance exchange, or consumer ombudsman program.

## **Monitor Reliance on Health Plan Accreditation as a Substitute for Confirming Compliance with Network Adequacy Standards**

The NAIC and DOIs should monitor the practice of relying on health plan accreditation as an option for health plans to demonstrate compliance with network adequacy standards. While accreditation standards can play a meaningful role in states that have minimal network adequacy requirements or can supplement information DOIs rely on for confirming network adequacy, accreditation should not be viewed as a substitute for meaningful network adequacy and access to care standards. States that accept accreditation should clearly identify additional requirements for demonstrating network adequacy and should not rely solely on self-attestation by health plans

## **Recommendations for Amending the NAIC Managed Care Plan Network Adequacy Model Act**

Based on the recommendations noted above, we have included suggestions for amending the Managed Care Plan Network Adequacy Model Act. Our suggested edits, as submitted to the NAIC's Network Adequacy Model Review Subgroup on July 3, are included in Appendix B. Revisions are provided in tracked change mode in order to assist the Subgroup in its development of proposed changes to the Model.

Finally, we want to reiterate our appreciation to the NAIC for its support of our survey project and development of this report. With continued concerns about the rising costs of health care, the use of provider networks will continue to be an important issue, and we are pleased to see the NAIC's commitment to updating the Model Act. We realize regulators are faced with many critical concerns and growing pressure from many fronts, and are grateful for the opportunity to participate in the development of new network adequacy regulations and solutions.

# Appendix A: Insurance Department Survey of Network Adequacy Regulatory Requirements and Oversight.

## Insurance Department Survey of Network Adequacy Regulatory Requirements and Oversight

May 28, 2014

**Please Note That All Survey Responses Are Confidential.**

State: \_\_\_\_\_ Survey Respondent Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**Section A: Please answer each of the following questions as it applies to your Department's activities related to network adequacy regulatory oversight.**

**1. Has your state adopted the NAIC Managed Care Plan Network Adequacy Model Act (Model #74)?**

- a. \_\_\_\_\_ Yes, we have adopted the NAIC Model Act as written, or with minor revisions.
- b. \_\_\_\_\_ Yes, we have adopted portions of the NAIC Model Act, but with significant revisions.
- c. \_\_\_\_\_ No, we have not adopted the NAIC Model Act.
- d. \_\_\_\_\_ Uncertain of our state's status.

**2. Indicate which of the following complaint codes, or codes with very similar descriptions, are included in your complaint tracking system to enable the identification of complaints related to network adequacy or access to care:**

- a. \_\_\_\_\_ Inadequate Provider Network
- b. \_\_\_\_\_ Network Adequacy
- c. \_\_\_\_\_ Access to Care
- d. \_\_\_\_\_ Timely Access to Care
- e. \_\_\_\_\_ Inaccurate Provider Directory
- f. \_\_\_\_\_ Out-of-Network Claim Dispute/Resolution
- g. \_\_\_\_\_ Out-of-Network Services
- h. \_\_\_\_\_ Formulary Restrictions
- i. \_\_\_\_\_ Balance Billing
- j. \_\_\_\_\_ Other (Please describe) \_\_\_\_\_

**3. On a scale of 1 to 5 (1 is the least significant, 5 is the most significant), how significant are the following challenges in the regulation and oversight of network adequacy?**

- a. \_\_\_\_\_ Maintaining adequate trained staffing levels for network analysis activities
- b. \_\_\_\_\_ Obtaining complete and accurate network adequacy data files from health plans and conducting a thorough review at licensure
- c. \_\_\_\_\_ Monitoring and identifying network adequacy problems on an ongoing basis once the initial plan has been filed and approved
- d. \_\_\_\_\_ Ensuring health plan enrollees have sufficient information to understand the risks and potential costs associated with receiving out-of-network services
- e. \_\_\_\_\_ Lack of authority to exercise increased oversight and impose enforcement actions and penalties
- f. \_\_\_\_\_ Please identify any additional challenges you have encountered: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Does your state have any required provisions/notifications in health plan member handbooks, disclosure document requirement for enrollment, or other documents distributed by health plans, that are designed to ensure consumers are adequately informed of the circumstances in which a member may see an out-of-network provider, and how to avoid doing so?**

a. \_\_\_\_\_ No

b. \_\_\_\_\_ Yes; Please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Does your state have any “transparency” requirements or network adequacy provisions designed to prohibit or limit circumstances when no facility-based physician (i.e., anesthesiologist, pathologist, radiologist, ER physician, etc.) is available to a patient, even though the hospital/facility is in the patient’s network? If so, please describe**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**6. On a scale of 1 to 5 (1 is low, 5 is high), indicate the extent to which you believe your state’s current requirement for regular reporting of the following health plan data is important (or you believe it would assist your Department in the oversight/monitoring of network adequacy, if it were required):**

a. \_\_\_\_\_ Aggregated data on number/percentage of out-of-network claims

b. \_\_\_\_\_ Data on number/percentage of out-of-network claims by service area

c. \_\_\_\_\_ Claims value of out-of-network claims

d. \_\_\_\_\_ Reimbursement rate payments for in-network claims vs. out-of network claims

e. \_\_\_\_\_ Number of complaints filed with health plan regarding problems accessing care, receipt of care by out-of-network providers, claims payment of out-of-network services

f. \_\_\_\_\_ Number of complaints filed with health plan regarding inaccurate provider directory information

g. \_\_\_\_\_ Number of complaints filed with health plan regarding restriction of provider access due to enrollment in a narrow network

Please identify any additional data or information that would be helpful:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section B: Please complete the table below by placing an X in the corresponding column to indicate the response is applicable to requirements for HMOs and PPOs. If the response is not applicable, leave the column blank. If you do not know the answer, please enter NR.**

	HMOs	PPOs
<b>1. Under what circumstances does the Department review a health plan’s network? (Check all that apply).</b>		
a. Upon application for licensure		
b. When adding a new service area or expanding an existing area		
c. Regularly Scheduled Periodic Review (i.e., annually, semiannually, biennially, etc.)		
d. When complaints or other market conduct oversight activities indicate a potential problem		
e. Routinely required as part of a market conduct examination		
f. When a health plan files a notice of significant change to their network		
g. Other (describe)		
<b>2. Does the Department require plans to submit GEO-Access maps or equivalent as part of their provider network filing? Check box if Yes.</b>		
<b>3. Does the Department contract with a vendor for the review and analysis of provider network file submissions? Check box if yes.</b>		
<b>4. Which of the following describes information that is reviewed as part of the initial provider network review process? Check all that apply.</b>		
a. The entire filing is reviewed in detail and tested against GEO Access standards to determine full compliance		
b. A sample of the network data files are reviewed in lieu of a full, comprehensive assessment of the network		
c. The state accepts the health plan’s attestation that the network filing complies with the Department’s requirements		
d. Department staff perform “secret shopper” calls to confirm providers are in the network and accepting new patients		
e. Review medical care referral patterns and hospital admission privileges to ensure participating providers have admitting privileges at in-network facilities		
f. Verify whether in-network hospitals contract with facility-based providers (i.e., radiologists, pathologists, anesthesiologists, emergency room physicians) who are in the health plan’s network		
g. Determine whether the network includes access to centers of excellence for transplants, cancer, and other critical services		
<b>5. Which of the following describes activities the Department uses to monitor network adequacy on an ongoing basis once a health plan’s network has been filed and approved?</b>		
a. Department collects out-of-network data from health plans to identify the extent to which members use out-of-network services.		
b. Department exercises more stringent oversight and monitoring of “Narrow Networks” that offer a more restricted network in exchange for reduced premium rates		
c. Department monitors health plan members’ ER utilization as a possible indicator of an inadequate network		
d. Department reviews health plan consumer satisfaction surveys to identify the extent to which enrollees report dissatisfaction with the network or access to care		
e. Department performs random survey of providers to confirm providers are in network, accepting new patients, confirm appointment availability timeframes, or other relevant information		

	HMOs	PPOs
f. Department monitors DOI complaints to identify trends or concerns that could indicate potential problems with network adequacy.		
g. Department requires health plans to report complaint information on volume of complaints related to network adequacy/access to care.		
Please describe any additional monitoring activities used:		
<b>6. Which of the following are applicable in your state?</b>		
a. Plans are required to resolve/pay claims for out-of-network emergency services in a way that ensures enrollees' costs are no more than what they would be for in-network services		
b. Plans are required to calculate claims payments for emergency out-of-network services based on specific criteria or a formula specified by statute or regulation		
c. Plans are required to calculate claims payments for non-emergency out-of-network services based on specific criteria or a formula specified by statute or regulation		
d. Health plans are required to comply with general criteria (such as usual, customary and reasonable) in the calculation of out-of-network claims payments		
e. Consumers are entitled to an independent arbitration process for negotiating health plan payments for out-of-network services		
Please describe any other requirements that apply to health plan payments for out-of-network services		
<b>7. Which of the following applies to network directory requirements?</b>		
a. Printed network directories must be updated at least semi-annually.		
b. Printed network directories must be updated at least annually.		
c. On-line directories must be updated at least monthly.		
d. On-line directories must be updated at least quarterly.		
e. For health plans that offer tiered or narrow networks that include a subset of providers, directories must clearly identify which providers participate in the restricted/narrow network.		
f. If a consumer relies on inaccurate information in a directory and is balance billed as a result, the health plan is responsible for resolving the claim in a way that holds the patient harmless.		
Please describe any additional requirements related to provider network directories:		
<b>8. Within the past 5 years, what is the annual average number of enforcement actions (fines, penalties, cease and desist, enrollment freezes, licensure revocation, etc.) the Department has taken based on violations related to network adequacy?</b>		
a. 0-1		
b. 2-3		
c. 4-5		
d. 5-10		
e. 11 or more		
f. Do not know		

	HMOs	PPOs
<b>9. Please indicate below how your state address network adequacy requirements for Point of Service (POS) plans and/or Exclusive Provider Organizations (EPOs). Please check all that apply.</b>		
a. POS plans are not subject to network adequacy requirements.		
b. EPOs are not subject to network adequacy requirements.		
c. POS plans are subject to the same network adequacy requirements that apply to Preferred Provider Organizations (PPOs).		
d. POS plans are subject to the same network adequacy requirements that apply to Health Maintenance Organizations (HMOs)		
e. POS plans are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs.		
f. EPOs are subject to the same network adequacy requirements that apply to PPOs.		
g. EPOs are subject to the same network adequacy requirements that apply to HMOs.		
h. EPOs are subject to separate network adequacy requirements that are different than those applicable to HMOs or PPOs.		
i. Other (please describe)		

**If your state has existing regulations and/or statutory provisions related to network adequacy requirements for managed care plans, please provide the appropriate citation/s below.**

HMO Network Adequacy Statutory or Regulatory citation/s:

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PPO Network Adequacy Statutory or Regulatory citation/s:

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Thank you for your assistance! Please return the completed survey to:  
**dlongley@healthmanagement.com**. Questions may also be submitted to this address,  
 or by calling Dianne Longley at 512-473-2626.

# Appendix B: Proposed Modifications to the NAIC Managed Care Plan Network Adequacy Model Act

These recommended modifications were submitted by Consumer Representatives to the NAIC to the NAIC's Network Adequacy Model Review Subgroup on July 3, 2014.

## **MANAGED CARE HEALTH BENEFIT PLAN NETWORK ADEQUACY ACCESS MODEL ACT**

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### **Section 1. Title**

This Act shall be known and may be cited as the ~~Managed Care~~ Health Benefit Plan Network Adequacy Access Act.

**Drafting Note:** In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

### **Section 2. Purpose**

The purpose and intent of this Act are to establish standards for the creation and maintenance of networks by health carriers and to assure the transparency, adequacy, accessibility and quality of health care services offered under a ~~managed care~~ network plan by establishing requirements for written agreements between health carriers offering ~~managed care~~ network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

**Drafting Note:** In states that regulate prepaid health services, this model may be modified for application to contractual arrangements between prepaid limited health service organizations that provide a single or limited number of health care services and the providers that deliver services to covered persons enrollees.

### Section 3. Definitions

For purposes of this Act:

- A. “Closed plan” means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan. “Balance billing” means the practice by a provider, who is not a participating provider in a covered person’s health benefit plan network, of charging the covered person the difference between the provider’s fee and the sum of the amount the covered person’s health benefit plan pays and what the covered person is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts as required by the health benefit plan.
- B. “Commissioner” means the insurance commissioner of this state.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- C. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- D. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- E. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.
- F. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition.
- G. “Essential community provider” means providers that serve predominantly low-income, medically underserved individuals, including providers defined in section 340B(a)(4) of the Public Health Services Act and tax exempt entities that meet the requirements of that standard except that they do not receive funding under that section.
- G. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- H. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- I. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

**Drafting Note:** States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate “persons.”

- J. “Health care provider” or “provider” means a health care professional or a facility.
- K. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- L. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- M. “Health indemnity plan” means a health benefit plan that does not use a network arrangement to deliver health benefits or services.
- N. “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.
- O. “Managed care plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier. “Network plan” means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

**Drafting Note:** The definition of “managed care network plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others, such as HMOs, EPOs, PPOs, POS and including accountable care organizations (ACOs) and other new models of care delivery. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. The standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.

- P. “Network” means the group of participating providers or preferred providers providing services to covered persons through a managed care network plan that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use participating providers managed, owned, under contract with or employed by the health carrier or a preferred provider organization.
- Q. “Open plan” means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.
- R. “Participating provider” means a provider facility or health care professional who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.
- S. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- T. “Preferred provider” means a participating provider.
- U. “Primary care professional” means a participating health care professional provider designated by the health carrier to who supervises, coordinates or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.
- V. “Tiered provider network” means a network that identifies and groups participating providers into specific groups that reflect different provider reimbursement, require different cost-sharing by a covered person, or feature different provider access requirements, or any combination, thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize covered person or provider behavior.

## Section 4. Applicability and Scope

This Act applies to all health carriers that offer managed-care network plans.

**Drafting Note:** States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards that are substantially similar to the standards required under this Act, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity should make available to the state its current standards to demonstrate that the entity's standards are comprehensive and meet or exceed the state's requirements. Accreditation should not rely exclusively on health plan self-attestation or a review of the carrier's policies and procedures and should include independent confirmation of network adequacy. Further, retrospective analyses of consumer complaint data should demonstrate that the accreditation standard results in adequate networks for covered persons. The private accrediting entity shall file or provide the state with documentation that a network plan has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist, except that accreditation should never exempt a health carrier from filing an access plan as required by Section 5. States should periodically review a health carrier's private certification and eligibility for deemed compliance. A health plan should be required to notify States upon loss of accreditation or a change in accreditation status to a lower level, at which time the State would initiate an immediate review of the health plan's network to determine whether the plan meets the State's network adequacy requirements.

## Section 5. Network Adequacy

- A. A health carrier providing a managed-care network plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits, including primary, specialty, institutional, and ancillary services to covered persons will be accessible without unreasonable travel or delay. In the case of emergency services, covered persons shall have access within a reasonable proximity of xx miles twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including but not limited to: provider covered person ratios by specialty; primary care provider covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.
- (1) For the purposes of this section, a carrier's network is sufficient if the carrier:
- (a) Demonstrates that for primary care:
    - (i) The ratio of primary care providers to enrollees within the carrier's service area as a whole meets or exceeds the average ratio for the state for the prior plan year;
    - (ii) xx percent of covered persons within the service area are within xx miles of a sufficient number of primary care providers in an urban area and xx miles of a sufficient number of primary care providers in a rural area; and
    - (iii) Covered persons have access to an appointment with a primary care provider within xx days of requesting one.
  - (b) Demonstrates that for specialty care:
    - (i) Covered persons have access to an adequate range of specialists sufficient to deliver services covered under the policy or contract and located within xx miles in an urban area and within xx miles in a rural area.
    - (ii) Covered persons have access to any needed specialist necessary to deliver services covered under the policy or contract within xx days of referral or requesting of an appointment for non-urgent services.
  - (c) Demonstrates that for general hospital facilities with emergency care, each covered person in the network has access within xx minutes (or miles) in an urban area or xx minutes (or miles) in a rural area.
  - (d) Demonstrates that for essential community providers, at least the percent of essential community providers located in the plan's service area participate in the provider network as is required for qualified health plans in the state.
  - (e) Demonstrates that for other covered services, the network is sufficient to meet any other standards set by the commissioner.

Drafting Note: Quantitative regulatory standards should establish a floor of consumer protection to ensure adequate access to covered benefits, but we recognize that geography and local market conditions make it challenging to set a national standard that would be appropriate in every state. Therefore, each state should determine the appropriate quantitative standards. States may wish to look to the Medicare Advantage program, which establishes time and distance limits that vary based on five different types of geographic areas, as a model for establishing its standards.

- (2) In any case where the health carrier has an insufficient number or type of participating provider with the training and experience necessary to provide a covered benefit within a reasonable proximity or timeframe, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.
  - (2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.
  - (3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons.
- B. If at the determination of the commissioner, there is not adequate choice between plans using broad and narrow or ultra-narrow networks in a service area, a health carrier offering a network plan in that area that provides coverage through a narrow or ultra-narrow network of participating providers, as defined by the commissioner, shall also offer at least one health benefit plan with a broad network of participating providers or an out-of-network benefit in that service area, unless the carrier can demonstrate good cause to the commissioner that such a plan is not feasible.
- C. Beginning [insert effective date], a health carrier shall file with submit to the commissioner for approval prior to or at the time it files a newly offered network plan, in a manner and form defined by rule of the commissioner, an access plan meeting the requirements of this Act for each of the managed care network plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on a publicly accessible website, its business premises, and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care network plan, and shall update an existing access plan within 15 business days of any whenever it makes any material change to an existing managed care network access plan. Each network access plan shall describe or contain at least the following:

**Drafting Note:** Different states will set different requirements for the access plan. This model requires a health carrier to file submit the plan with the insurance commissioner but does not require the commissioner to take action on the plan for prior approval. Some states may want to require the commissioner's approval of access plans; other states may prefer that a health carrier not file the access plan with the commissioner but instead maintain the plan on file at the carrier's place of business and make it accessible to the commissioner and others specified by the commissioner not require the commissioner to take action on the plan. Some states may also specify an agency other than the insurance department as the appropriate agency to receive or approve access plans.

- (1) The health carrier's network, including how the use of telehealth or other technology may be used to meet network access standards;
- (2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;
- (3) 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 managed care network plans, including the use of evening and weekend hours for non-emergency care;
- (4) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
- (5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

- (6) The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;
- (7) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- (8) The health carrier's process for enabling covered persons to change primary care professionals;
- (9) 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 transferred to other providers in a timely manner; ~~and~~
- (10) The health carrier's efforts to ensure the providers in its network report on and meet standards for quality of care and health outcomes.
- (11) The health carrier's protocol for maintaining, updating and publicly posting its network directory of participating providers specific to each network plan, including whether accepting new patients, languages spoken, and office hours and locations;
- (12) The health carrier's method for publicly conveying the overall breadth or narrowness of the provider network, along with the method used to select providers for the network, for each network plan; this public information should be sufficient to signal to consumers at a summary level how provider networks compare across health benefit plans; and
- (13) Any other information required by the commissioner to determine compliance with the provisions of this Act.

## Section 6. Requirements for Health Carriers and Participating Providers

A health carrier offering a ~~managed care~~ network plan shall satisfy all the requirements contained in this section.

- A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.
- B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision 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.”
- C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons

confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

- D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and 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 required by Subsections B and C of this section.
- E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.
- F. (1) Health carrier selection standards for selecting or tiering of participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used uniformly in determining the selection or tiering of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. The standards shall meet the requirements of [insert reference to state provisions equivalent to the Health Care Professional Credentialing Verification Model Act]. Selection or tiering criteria shall not be established in a manner:
- (a) That would allow a health carrier to avoid high risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization;
  - (b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization; or
  - (c) That does not take into account provider performance on quality metrics and patient outcomes.
- (2) Paragraphs (1)(a), ~~and~~ (1)(b) and (1)(c) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Act.
- (3) The provisions of this Act do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

**Drafting Note:** This subsection is intended to prevent health carriers from avoiding risk by excluding either of two types of providers: (1) those providers who are geographically located in areas that contain potentially high risk populations; or (2) those providers who actually treat or specialize in treating high risk populations, regardless of where the provider is located. Exclusion based on geographic location may discourage individuals from enrolling in the plan because they would be required to travel outside their neighborhood to obtain services. Exclusion based on the provider's specialty or on the type of patient contained in the provider's practice may discourage a person unwilling to change providers in the course of treatment from enrolling in the plan. For example, if a carrier were permitted to exclude physicians whose practices included many patients infected with HIV, the carrier could avoid enrolling these persons in its plan, since those persons would probably not want to change physicians in the course of treatment. This subsection does not prevent health carriers from requiring all providers that participate in the carrier's network to meet all the carrier's requirements for participation.

- G. A health carrier shall make its ~~selection~~ standards for selecting or tiering participating providers available for review and approval by the commissioner.

**Drafting Note:** The disclosure of a health carrier's selection standards to providers and consumers is an important issue to be considered by states and could be addressed in this Act or in another law. The NAIC is considering developing such a model.

- H. A health carrier shall ensure via contract with a facility that is a network provider that a covered person will not be subject to balance billing for services rendered in that facility by an out-of-network health care professional, unless the covered person authorizes in writing and in advance of receipt of services that he/she has chosen to be treated by an out-of-network health care professional and is aware of the additional costs applicable as a result of selecting an out-of-network provider.

- I. A health carrier shall notify 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 procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.
- J. A health carrier shall not offer an inducement or a financial penalty under the managed care provider network plan contract to encourage a provider to provide less services or less costly services than are than medically necessary services to a covered person.
- K. A health carrier shall not prohibit or discourage a participating provider from discussing 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 processes established by the carrier or a person contracting with the carrier.
- L. A health carrier shall require a 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 the applicable state and federal laws related to the confidentiality of medical or health records.
- M. (1) A health carrier shall post the current provider directory for each network plan online and must make a printed copy of the current provider directory available to a covered person or prospective covered person upon request. Provider directories must be updated at least monthly and must be offered in a manner to accommodate individuals with limited-English proficiency or disabilities.
- (2) For each network plan, the associated provider directory must include in plain language, as clearly as possible, the following general information about the plan:
- (a) The type of plan (i.e. HMO, PPO, EPO, etc.) and whether there is any coverage for services provided by out-of-network providers;
  - (b) The methodology used, if any, for determining the payment amount for out-of-network services;
  - (c) Detailed, consumer-oriented explanation of the risks and potential costs associated with receiving out-of-network services;
  - (d) The breadth of the network, as defined by the commissioner (i.e. broad, narrow, or ultra-narrow);
  - (e) The standards or criteria used for including or tiering a participating provider and the cost-sharing and out-of-pocket limit differentials that may result from using a non-participating provider or a provider in a tier other than the lowest cost-sharing tier;
  - (f) The health benefit plan's protocol for using out-of-network providers but with in-network cost-sharing for situations where a suitable in-network provider is not available on a timely basis; and
  - (g) Identification of any in-network facilities at which there are no contracts with a class of facility-based providers, specifying the particular provider class.
- (3) For each health benefit plan, the associated provider directory must include the following information for each provider:
- (a) The specialty area or areas for which the provider is licensed to practice and included in the network;
  - (b) Location and contact information;
  - (c) Any in-network institutional affiliations of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;
  - (d) Whether the provider may be accessed without referral;
  - (e) If applicable, whether the provider is assigned to a specific tier, and if so, to which tier each participating provider is assigned;
  - (f) Education and board certification information;
  - (g) Whether the provider is currently accepting new patients;

- (h) Any languages, other than English, spoken by the provider; and
- (i) Accommodations made by the provider for persons with disabilities; and
- (j) Provider quality of care information.

(4) If an issuer maintains more than one provider network, it should be clear to covered persons and prospective covered persons what provider directory applies to which network plan and covered persons or prospective covered persons may not be required to log on or enter a policy number in order to access the applicable provider directory.

N. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier and participating provider shall make a good faith effort to provide written notice of a termination within fifteen (15) working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier. In the case of a termination of a contract or assignment of a provider to a different cost-sharing tier, a health carrier and participating provider shall agree to provide continuing coverage for a covered person who is pregnant, terminally ill, or in the midst of an active course of treatment for a serious medical condition for 90 days or until the course of treatment is completed, whichever is longer, under the same cost-sharing rules that would apply if the contract or tier placement was still in force.

O. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

**Drafting Note:** In order to assure continued provider participation, a state may wish to restrict the right of a health carrier to assign or delegate its contract with a provider without prior written notice to the provider.

- P. A health carrier is responsible for ensuring 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.
- Q. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.
- R. A health carrier shall 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.
- S. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier.
- T. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.
- U. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the ~~managed care~~ network plan or this Act.

## Section 7. Special Enrollment Periods

A health carrier must provide special enrollment periods for the following triggering events:

- (1) An individual's enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in the provider directory, including but not limited to a provider being listed as a participating provider that is not part of the network or a provider incorrectly being listed as accepting new patients;
- (2) A covered person's primary care provider becomes a non-participating provider during a plan year or policy year;
- (3) A covered person who is in the midst of a course of treatment for pregnancy or a serious medical condition loses access to their specialty care provider or facility because the provider becomes a non-participating provider or is moved to a higher cost-sharing tier during the plan year or policy year.

## Section 8. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

- A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 6.
- B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.
- C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.
- E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.
- F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them for [cite applicable statutory duration] in a manner that facilitates regulatory review.
- G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Act.
- H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

## Section 9. Filing Requirements and State Administration

- A. Beginning [insert effective date], a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.
- B. A health carrier shall submit material changes to a contract that would affect a provision required by this statute or implementing regulations to the commissioner for approval [cite period of time in the form approval statute] days prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection, unless such changes may impact a covered person's access to covered services from a contracted provider in a timely manner.
- C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.
- D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

## Section 10. Contracting

- A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.
- B. All contracts shall be in writing and subject to review.

**Drafting Note:** Each state should add provisions that are consistent with that state's current regulatory requirements for the approval or disapproval of health carrier contracts, documents or actions. For example, a state may want to add a provision requiring a health carrier to obtain prior approval of contracts, or requiring a health carrier to file a contract before using it, or requiring a health carrier to certify that all its contracts comply with this Act.

- C. All contracts shall comply with applicable requirements of the law and applicable regulations.

## Section 11. Enforcement

- A. If the commissioner determines that a health carrier has not contracted with a sufficient number of ~~enough~~ participating providers to assure that covered persons have accessible health care services in a geographic area, 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 this Act, or that a health carrier has not complied with a provision of this Act, the commissioner shall institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Act.

**Drafting Note:** In addition to the prior approval of network access plans, the commissioner should use other tools at his/her disposal to ensure ongoing compliance with the Act's requirements, including but not limited to data collection on use of out-of-network services, consumer surveys, unscheduled audits, secret shopper surveys, and/or tracking of consumer complaints. In addition, data collection on the following elements directly from network plans would be useful: number of complaints filed regarding problems accessing care, receipt of care by out-of-network providers, claims payment of out-of-network providers; number of complaints regarding inaccurate provider directory information; number of complaints filed regarding restriction of provider access due to enrollment in a narrow framework

- B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a ~~managed-care~~ network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination, unless such action violates a requirement of this Act.

## Section 12. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

## Section 13. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

## Section 14. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

## Section 15. Effective Date

This Act shall be effective [insert date].

- A. All provider and intermediary contracts in effect on [insert effective date] shall comply with this Act no later than eighteen (18) months after [insert effective date]. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.
- B. A new provider or intermediary contract that is issued or put in force on or after [insert a date that is six (6) months after the effective date of this Act] shall comply with this Act.
- C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Act no later than eighteen (18) months after [insert effective date].

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*Chronological Summary of Action (all references are to the Proceedings of the NAIC).  
1996 Proc. 2nd Quarter 10, 30, 732, 767, 770-777 (adopted).*

## Appendix C: Definition of Terms

The following terms are used frequently throughout this report. These definitions are provided to help the reader understand the distinctions between the various types of health plans that use networks of providers. The definitions are from the Glossary of Insurance Terms available at: <https://www.healthcare.gov/glossary/>.

### **Exclusive Provider Organization (EPO)**

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

### **Health Maintenance Organization (HMO)**

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

### **Point of Service Plan (POS)**

A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

### **Preferred Provider Organization (PPO)**

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

- <sup>1</sup> Note, the scope of this report is limited to the inclusion of health care providers, including pharmacists, in health plans' networks; the inclusion or exclusion of specific pharmaceuticals in health plan formularies is beyond its scope.
- <sup>2</sup> Testimony of Monica J. Lindeen, Montana Commissioner of Securities and Insurance Before the House Energy and Commerce Subcommittee on Health, June 12, 2014; available at:
- <sup>3</sup> See Appendix C for definition of terms.
- <sup>4</sup> "Report of the Health Network Adequacy Advisory Committee," Texas Department of Insurance, January 2009. Available at: <http://www.tdi.texas.gov/reports/life/documents/hlthnetwork09.doc>
- <sup>5</sup> Both Medicaid and Medicare managed care plans are also subject to network adequacy requirements, but are not included in this report due to the additional complexities and unique program requirements of these benefit programs.
- <sup>6</sup> See Appendix C for definitions of terms.
- <sup>7</sup> See <http://www.tdi.texas.gov/reports/life/documents/hlthnetwork09.doc> <http://www.tdi.texas.gov/reports/life/documents/hlthnetwork409b.doc> for two reports prepared by the Texas Department of Insurance (TDI) to better inform Texas Legislature as it discussed network adequacy as it relates to facility-based providers and out-of-network balance billing. TDI issued an initial report based on preliminary data submitted voluntarily by a small number of health plans, and a subsequent report that included the results of a statewide data call. Also see <http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf> for a report on balance billing and network adequacy problems identified by the New York Department of Financial Services.
- <sup>8</sup> See Surprise Medical Bills Take Advantage of Texans by Stacey Pogue, Center for Public Policy Priorities, found at [http://forabettertexas.org/images/HC\\_2014\\_09\\_PP\\_BalanceBilling.pdf](http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf) and [http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?emc=edit\\_tnt\\_20140928&nlid=58462464&ntemail0=y&utm\\_campaign=KHN%3A+Daily+Health+Policy+Report&utm\\_source=hs\\_email&utm\\_medium=email&utm\\_content=14297537&\\_hsenc=p2ANqtz-LsZED-GqHn\\_mP3Jl34plPaW3jypRREnXW7N72CjctYD8F9NlVWI\\_QMmm8Vf9NKz6yEauOXRSSj0VssGw4Rxxq8Ls\\_KmDHFf7jXMCn0qc6q6Hg&\\_hsmi=14297537&\\_r=1](http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html?emc=edit_tnt_20140928&nlid=58462464&ntemail0=y&utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=14297537&_hsenc=p2ANqtz-LsZED-GqHn_mP3Jl34plPaW3jypRREnXW7N72CjctYD8F9NlVWI_QMmm8Vf9NKz6yEauOXRSSj0VssGw4Rxxq8Ls_KmDHFf7jXMCn0qc6q6Hg&_hsmi=14297537&_r=1)
- <sup>9</sup> Corlette S, Lucia K, Ahn S, Implementation of the Affordable Care Act: Six-State Case Study on Network Adequacy, the Urban Institute, Sep. 2014. Available from <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>.
- <sup>10</sup> <http://capsules.kaiserhealthnews.org/index.php/2014/09/consumer-groups-sue-2-more-calif-plans-over-narrow-networks/> and [http://www.latimes.com/business/la-fi-0928-obamacare-doctors-20140928-story.html?utm\\_campaign=KHN%3A+Daily+Health+Policy+Report&utm\\_source=hs\\_email&utm\\_medium=email&utm\\_content=14297537&\\_hsenc=p2ANqtz-8LXMMMPVLWAFREzBxZUUEAN--Ok2tlogb2nzi5xtQ6lapLnFnEdcpkDQoRO8bo6qH2I9FqibK\\_PZLBBsQzOIAmZn0Cn7Jli5MncGhYTj1kjp-46xc&\\_hsmi=14297537#page=1](http://www.latimes.com/business/la-fi-0928-obamacare-doctors-20140928-story.html?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=14297537&_hsenc=p2ANqtz-8LXMMMPVLWAFREzBxZUUEAN--Ok2tlogb2nzi5xtQ6lapLnFnEdcpkDQoRO8bo6qH2I9FqibK_PZLBBsQzOIAmZn0Cn7Jli5MncGhYTj1kjp-46xc&_hsmi=14297537#page=1)
- <sup>11</sup> "State network regulation dispute portends national challenges," Healthcare Payer News, April 24, 2014. Available at: <http://www.healthcarepayernews.com/content/state-network-regulation-dispute-portends-national-challenges>
- <sup>12</sup> <http://www.kaiserhealthnews.org/stories/2013/november/25/states-balk-at-narrow-networks.aspx>
- <sup>13</sup> <http://www.concordmonitor.com/news/12412914-95/qa-what-changes-are-coming-to-the-new-hampshire-insurance-marketplace-in-2015>. Additional information on changes included in the new rule is available at: [http://www.nh.gov/insurance/legal/documents/na\\_presentation\\_07.24.14.pdf](http://www.nh.gov/insurance/legal/documents/na_presentation_07.24.14.pdf)
- <sup>14</sup> Stacey Pogue, "Surprise Medical Bills Take Advantage of Texans: Little-known practice creates a "second emergency" for ER patients," Center for Public Policy Priorities, September 15, 2014. Available at: [http://forabettertexas.org/images/HC\\_2014\\_09\\_PP\\_BalanceBilling.pdf](http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf)
- <sup>15</sup> "An Unwelcome Surprise: How New Yorkers are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers," New York State Department of Financial Services. Available at: <http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf>
- <sup>16</sup> Note that this report only addresses network adequacy requirements in the commercial market and does not include separate requirements applicable to Medicaid managed care plans.
- <sup>17</sup> [http://www.naic.org/documents/index\\_health\\_reform\\_comments\\_140423\\_naic\\_letter\\_ccio\\_network\\_adequacy.pdf](http://www.naic.org/documents/index_health_reform_comments_140423_naic_letter_ccio_network_adequacy.pdf)
- <sup>18</sup> "FAQs about Affordable Care Act Implementation (Part XXI)." October 10, 2014. Accessed online at: <http://www.dol.gov/ebsa/faqs/faq-aca21.html>
- <sup>19</sup> Section 2702(c) of the Public Health Service Act allows plans using provider networks to limit their enrollment to individuals who live, work, or reside within their service areas. In addition, plans may close enrollment to additional members demonstrate they are applying their capacity measures uniformly and not selectively, and can demonstrate they do not have the capacity to serve additional enrollees.
- <sup>20</sup> <http://www.dol.gov/ebsa/faqs/faq-aca21.html>
- <sup>21</sup> 45 CFR Parts 155,156,157, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers". Department of Health and Human Services.
- <sup>22</sup> Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-0090-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-P), Regulatory Impact Analysis; Center for Consumer Information and Insurance Oversight. March, 2012. Available at: <http://ccio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf>
- <sup>23</sup> In the preamble Section II A(1)(b) related to definitions, HHS states that several commenters suggested HHS define "limited English proficient." HHS reports they plan to issue future guidance that will include best practices and advice related to meaningful access standards for limited English proficient individuals.
- <sup>24</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, "Introduction to 340B Drug Pricing Program". Available online at: <http://www.hrsa.gov/opa/introduction.htm>
- <sup>25</sup> "Essential Community Providers – Health Reform GPS: Navigating Implementation," George Washington University's Hirsch Health Law and Policy Program and the Robert Wood Johnson Foundation.
- <sup>26</sup> See updated reference to state compliance activities at: <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html>
- <sup>27</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>
- <sup>28</sup> "Managed Care Plan Network Adequacy Model Act," National Association of Insurance Commissioners, Model Regulation Service – October 1996. 1996 Proceedings of the NAIC, 2nd Quarter, 770-777.
- <sup>29</sup> The drafting note points out that this provision is designed to prohibit plans from creating a network that avoids risk by excluding providers who are located in areas that contain high-risk populations or providers who have a history of treating high-risk populations, such as individuals with HIV.
- <sup>30</sup> The drafting note states this requirement is an important issue for states and could be enacted in another law.
- <sup>31</sup> Drafting note suggests the states may want to consider a similar restriction against health carriers to ensure continued provider participation.
- <sup>32</sup> Please see Appendix C for additional information on Point of Service plans.

