Network Adequacy Model Review (B) Subgroup
Washington, District of Columbia
November 17, 2014

The Network Adequacy Model Review (B) Subgroup of the Regulatory Framework (B) Task Force met in Washington, DC, Nov. 17, 2014. The following Working Group members participated: J.P. Wieske, Chair (WI); Jill Jacobi (CA); Peg Brown (CO); Christina Goe (MT); Martin Swanson (NE); Adam Plain (NV); Gayle Woods (OR); Linda Johnson (RI); Chlora Lindley-Myers (TN); and Molly Nollette (WA). Also participating were: Jack McDermott (FL); Karl Knable (IN); Robert Wake (ME); and Mary Mealer (MO).

1. Adopted its Meeting Minutes

Ms. Brown pointed out a technical error in the Subgroup’s Sept. 11 minutes. She said that instead of saying “children are merely ‘small adults,’” the language needed to be revised to state that “children are not merely ‘small adults.’” The Subgroup agreed to the technical correction. Mr. Plain made a motion, seconded by Ms. Nollette, to adopt the Nov. 6 (Attachment Four-A), Nov. 3 (Attachment Four-B), Oct. 30 (Attachment Four-C), Oct. 27 (Attachment Four-D), Oct. 23 (Attachment Four-E), Oct. 20 (Attachment Four-F), Oct. 16 (Attachment Four-G), Oct. 14 (Attachment Four-H), Oct. 9 (Attachment Four-I), Oct. 2 (Attachment Four-J), Sept. 25 (Attachment Four-K), Sept. 18 (Attachment Four-L), Sept. 11 as revised (Attachment Four-M), Aug. 28 (Attachment Four-N) and Aug. 21 (Attachment Four-O) minutes. The motion passed unanimously.

2. Discussed Draft Revisions to Model #74

Mr. Wieske said that before reviewing the draft of revisions to the Managed Care Plan Network Adequacy Model Act (#74), he wanted to discuss the deadline for submitting public comments. He noted that the revisions to Model #74 would not be complete before state legislatures begin meeting in January 2015. As such, instead of the Dec. 1 public comment deadline, Mr. Wieske suggested changing it to Jan. 5, 2015. Candy Gallaher (America’s Health Insurance Plans—AHIP) said that given other deadlines and activities that industry and other stakeholders have related to the beginning of open enrollment in the health insurance exchanges, AHIP would like additional time for submitting comments. After discussion, the Task Force agreed to a Jan. 12, 2015, public comment deadline.

Jolie Matthews (NAIC) reviewed the draft of proposed revisions to Model #74 (Attachment Four-P) section-by-section. Beginning with Section 1—Title, she said the title was changed to “Health Benefit Plan Network Access and Adequacy Model Act” mostly to remove the reference to “managed care plan.” Ms. Matthews noted that the Subgroup may revisit this change in future. She said Section 2—Purpose was revised for clarity. However, two substantive changes were made: 1) adding the word “transparency”; and 2) adding a requirement that network plans have and maintain publically available access plans consistent with the requirements of Section 5B.

Ms. Matthews said Section 3—Definitions was revised to include definitions for new terms used in the revised model, including “balance billing” and “telemedicine or telehealth.” She said the definitions for “emergency medical condition” and “emergency services” were revised to more closely mirror the federal definitions for those terms. Ms. Matthews explained that a definition of “essential community provider” was added, although it is not used, at this point, in the revised model. She said the term was included because it is an important term. Qualified health plans (QHPs) are required to have a certain number or percentage of these types of providers in their provider networks in order to be certified to be offered on a health insurance exchange, as provided in the federal Affordable Care Act (ACA). Because of this, the states may want to use this term in any regulations they promulgate based on revisions to Model #74. Ms. Matthews pointed out that the definition of “managed care plan” was deleted and incorporated in the definition of “network plan.” She also pointed out the drafting note for “managed care plan” was deleted and moved to the definition of “network plan.” Ms. Matthews said she added a note to the Subgroup asking if the drafting note was still necessary and, if so, if it should be revised to better reflect current health care service delivery systems.

Turning to Section 4—Applicability and Scope, Ms. Matthews said that as requested by the Subgroup, the drafting note concerning accreditation was revised suggesting that states may consider accreditation as evidence of meeting some or all of Model #74’s requirements. However, she said language was added to the drafting note stating that accreditation should not be
used as a substitute for state regulatory oversight nor should it be considered a delegation of state regulatory authority in determining network adequacy. Ms. Matthews requested comments on whether the revised drafting note incorporated the Subgroup’s intent.

Ms. Matthews said Section 5—Network Adequacy was restructured for clarity. She pointed out the drafting note for Section 5A concerning tiered networks. The drafting note alerts the states to potential issues with such networks, such as network sufficiency. It also suggests that state insurance regulators may want to review what information health carriers are providing to consumers on a particular tiered network at the time of sale and also pay close attention to the benefits promised to the consumer by the carrier. Ms. Matthews pointed out the drafting note for Section 5B. She said the drafting note explains that the standards in Section B are general standards, but some states have developed specific quantitative standards that health carriers must satisfy in order to have a sufficient network for that network plan. The drafting note further explains that the general standards, as provided in Section 5B, are appropriate for incorporating into a state law, but quantitative standards are more likely to be included in regulation.

Turning to Section 5C, Ms. Matthews said Section 5C establishes an appeals and exceptions process for a covered person to obtain covered benefits from a non-network provider. She said health carriers must permit a covered person to use this process in two situations: 1) when the health carrier has a sufficient network, but has determined that it does not have a type of participating provider available to provide the covered benefits to the covered person; and 2) when the health carrier has an insufficient number or type of participating provider available to provide the covered benefit to the covered person. Ms. Matthews said Section 5E provides two options that the states can choose from regarding the access plan: 1) require the health carrier to submit the access plan to the commissioner for prior approval; and 2) require health carriers to file the access plan with the commissioner for informational purposes. She said Section 5E also was revised to require a health carrier to notify the commissioner of any material change to any existing network plan within 15 business days after the change occurs. The health carrier must include in the notice a reasonable time frame within which it will submit an updated existing access plan. Ms. Matthews said Section 5F was revised to include additional information that must be in an access plan, such as the health carrier’s process for updating its provider directories for each of its network plans and the criteria, in consumer-friendly language, the health carrier has used to build its provider network.

Ms. Matthews said Section 6—Requirements for Health Carriers and Participating Providers includes three major revisions. She said the first major revision is in Section 6C concerning the time frame a participating provider must continue to provide covered benefits to a covered person who was in an inpatient facility at the time of a health carrier or intermediary insolvency or other cessation of business. As revised, Section 6C provides that after the period for which premium has been paid, covered benefits will continue until the earlier of: 1) the effective date of new health benefit plan coverage; or 2) the covered person’s discharge from the inpatient facility because his or her continued confinement in the facility is no longer medically necessary. Ms. Matthews explained that the Subgroup also discussed adding a third parameter related to the exhaustion of the carrier’s assets or no guaranty fund coverage. However, the Subgroup deferred adding it because of concerns that guaranty fund coverage does not relate to network adequacy requirements.

Ms. Matthews said another major revision to Section 6 is in Section 6F(5). She said that as directed by the Subgroup, Section 6F(5) was revised to avoid any possible conflict with the provisions of Section 2706(a) of the federal Public Health Service Act (PHSA), as amended by the ACA. Section 2706(a) prohibits health carriers from discriminating against any health care provider, with respect to plan participation or coverage, who is acting within the scope of that provider’s license or certification under state law. Ms. Matthews noted that this provision does not require health carriers to contract with any health care provider who is willing to abide by the terms and conditions for plan participation (so-called “any willing provider” laws). She specifically asked for comments on whether this provision, as revised, addresses the possible conflicts with Section 2706(a) of the PHSA.

Ms. Matthews said the other major change to Section 6 is in Section 6L. Section 6L outlines the continuity of care requirements when a provider’s contract is terminated without cause. She noted that the time frame for health carriers to provide written notice of a provider’s termination to patients of the provider was extended from 15 working days to 30 days of receipt of the termination notice. Section 6L also was revised to add a requirement that a covered person be permitted to continue to receive covered benefits from the terminated provider for up to 90 days if the covered person was receiving active treatment for an acute or chronic medical condition.
Ms. Matthews said another provision was added to Section 6L to permit a covered person to continue to receive covered benefits for a specified time period from a terminated provider when the provider identifies a “special circumstance” with respect to the covered person. She said this language is based on Montana’s continuity of care provisions. Ms. Matthews also pointed out a drafting note for Section 6L suggesting that the states may want to review other state laws and regulations and consider providing covered persons a special enrollment right, particularly as related to continuity of care issues, when a consumer’s enrollment or non-enrollment in a health benefit plan is the result of a material error, inaccuracy or misrepresentation in a provider directory, including when a provider is listed as a participating provider, but subsequently is found not to be in an in-network, or a participating provider is listed as accepting new patients.

Ms. Matthews said two new sections—Section 7 and Section 8—were added to Model #74. She said Section 7—Disclosure and Notice Requirements requires health carriers for each of its network plans to develop a written disclosure or notice to be provided to covered persons at the time of pre-certification, if applicable, for a covered benefit to be provided at an in-network hospital that there is the possibility that the covered person could be treated by a provider that is not in the same network as the hospital. Section 7 also includes a similar requirement for hospitals.

Ms. Matthews said Section 8—Provider Directories requires health carriers to post online a current provider directory for each of its network plans with certain specified information related to participating providers and search functions that enable a consumer to search for a specific health care professional, hospital or other facility using certain parameters. Health carriers must update the provider directories at least monthly and must offer them in a manner to accommodate individuals with limited-English language proficiency or disabilities. Ms. Matthews said Section 8 also requires health carriers to have a print version of their provider directories that includes certain specified information. She pointed out a drafting note for Section 8, which suggests that the states may want to consider other ways to improve the accuracy of provider directories in addition to requiring them to be updated at least monthly. Such tools could include: 1) requiring health carriers in some manner, such as through an automated verification process, to contact providers listed as in-network who have not submitted claims within the past six months or other time frame the state may consider appropriate, to determine whether the provider still intends to be in-network; 2) requiring health carriers to internally audit their directories and modify them accordingly based on audit findings to access: a) whether their contact information is correct; b) whether they are really in the plan’s network; and c) whether they are taking new patients; and 3) closely monitoring consumer complaints.

Ms. Matthews said only a few changes were made to Section 9—Intermediaries. She said a new subsection was added to Section 9 to make it clear that the health carrier is always responsible for an intermediary’s compliance with the provisions of Model #74. In addition, a drafting note was added to Section 9 suggesting that the states may want to consider requiring intermediaries to register with the state department of insurance, or other state agency, or impose some other regulatory scheme on such entities to ensure the state has the regulatory authority to regulate them and keep track of their activities.

Ms. Matthews said Section 10—Filing Requirements and State Administration was revised to permit a state to require health carriers either, as the state feels is appropriate, to submit contract forms to the commissioner for prior approval or require health carriers to file contract forms with the commissioner for informational purposes. She said a drafting note was added to Section 10 suggesting that the states consider when a health carrier makes changes in contracted provider payment rates, coinsurance, copayments or deductibles or other plan benefit modifications, that such changes could materially affect a covered person’s access to covered benefits or timely access to participating providers. If there is a material impact, such changes should be filed with the commissioner for prior approval or for informational purposes, as appropriate.

Ms. Matthews said no changes were made to Section 11—Contracting. She said Section 12—Enforcement was revised to provide an option for the commissioner to order a health carrier to submit a modified access plan instead of a corrective action plan under certain circumstances. Ms. Matthews said a drafting note was added to Section 12 to alert the states that state insurance regulators may use a variety of tools and/or methods to determine a health carrier’s ongoing compliance with Model #74 and whether the health carrier’s provider network for its network plans is sufficient and provides covered persons with reasonable access to covered benefits. Those tools and/or methods include consumer surveys, reviewing and tracking consumer complaints, and data collection on the use of out-of-network benefits.

Ms. Matthews said no changes were made to Section 13—Regulations, Section 14—Penalties, Section 15—Separability or Section 16—Effective Date.

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Mr. Wieske asked for comments. Ms. Mealer said that because of her personal experience, she believes that Model #74 should require health carriers to include in their networks hospitals that provide specialty pediatric hospital services. Stephanie Mohl (American Heart Association—AHA) said the NAIC consumer representatives will be submitting a comment letter to the Subgroup by the Jan. 12 deadline. However, initially, she said the NAIC consumer representatives’ comment letter will suggest that Section 5—Network Adequacy include additional clarity as to what is a “sufficient” provider network and what is meant by “unreasonable” delay. She said the NAIC consumer representatives also most likely will suggest additional revisions to further address the issue of balance billing, particularly as related to non-emergency services. Ms. Mohl acknowledged that the ACA includes requirements that prohibit health carriers from balance billing as to emergency services. However, these requirements do not apply to providers. She also said the NAIC consumer representatives will suggest improvements to Section 8—Provider Directories. Ms. Mohl said the NAIC consumer representatives also will suggest additional revisions to Model #74 to address the mid-year changes of participating providers to a higher tier with different cost-sharing requirements.

Ms. Goe asked if Ms. Mohl had any suggestions on how state insurance regulators can address balance billing with respect to providers because state insurance regulators have no regulatory authority over providers. Ms. Mohl suggested that one way would be through the in-network hospital by requiring the hospital to include a hold harmless clause in its contract with providers. Mr. Wake suggested that incentives could be created to have health carriers, hospitals and providers work out their contractual disputes. He also reiterated his suggestion that the health carrier be required to always hold the covered person harmless from balance billing. Mr. Wake also suggested that the Subgroup could consider adding back the definition of “closed plan” and require that such plans include a hold harmless provision in contracts with their participating providers.

Lee Spangler (Texas Medical Association—TMA) encouraged the Subgroup to make sure the revisions to Model #74 give state insurance regulators the necessary tools to ensure health carriers correct any problems and/or violations of any of its provisions. Jan Kaplan (Children’s Hospital Association—CHA) reminded the Subgroup that children are not little adults; they have unique health care needs. She said there must be criteria included in Model #74 to ensure health carriers include pediatric hospitals in the provider network for their network plans. Ms. Kaplan also said consumers should not have to rely on a health carrier’s exceptions or appeals process to obtain the health care services they need. Chad Moore (Children’s Mercy Hospital Kansas City) described the issues the Children’s Mercy Hospital has experienced as far as being included in the provider network of QHPs. He said the hospital had always been an in-network provider for health benefit plans until emergence of the health insurance exchanges. Dr. Moore said that in the current environment, these network issues are resolved through back-end fixes, which is problematic for some families and is administratively burdensome. Ms. Goe said pediatric hospitals can be considered essential community providers for purposes of inclusion in a provider network. Ms. Kaplan agreed, but said such a designation may not work because pediatric hospitals are grouped together as one essential community provider.

Mr. Wake suggested that the Subgroup consider adding simple language to address the issue of tiered networks by adding substantive language to Model #74, instead of relying on the drafting note in Section 5—Network Adequacy, requiring the commissioner to consider the nature of the network and whether covered persons have reasonable access to participating providers.

Kelly Kenney (Physicians Advocacy Institute—PAI) said the revisions to Section 5—Network Adequacy appear to still provide due deference to health carriers, similar to a self-assessment that they are meeting Model #74’s network adequacy requirements. She suggested that the Subgroup vote on whether to include quantitative standards in the substantive language of Section 5, and not refer to such standards in a drafting note. Ms. Kenney also suggested that Model #74 be revised to include stronger enforcement language. She said she will be submitting a comment letter detailing the PAI’s concerns on these issues. Mr. Wieske said that if quantitative standards were included in the model law and a state adopted them in a state statute, then the statute would have to be amended by the state legislature each time there was a change in the standards. He said it is more appropriate to include quantitative standards in regulations for that reason.

Nathaniel Counts (Mental Health America) alerted the Subgroup to provider selection issues for mental health service providers.

Having no further business, the Network Adequacy Model Review (B) Subgroup adjourned.